EXHIBIT B

Graduate Medical Education

Red Book

Policy & Procedure Manual For Residents and Fellows

2008-09

MARY HITCHCOCK MEMORIAL HOSPITAL

Graduate Medical Education Policy and Procedure Manual
For Residents and Fellows
Approved by GMEAC

All information is deemed to be accurate at time of publication.

Contents subject to change.

Table of Contents

I. About Graduate Medical Education

Overview

Graduate Medical Education is the phase of formal medical education beginning at graduation from medical school and ending after the educational requirements for one of the medical specialty certifying boards have been completed. The objective is to prepare physicians for the independent practice of medicine.

State licensing boards have varying requirements for post-MD clinical training, and almost every medical school graduate now spends from three-to-seven years in postgraduate training. The term "residency" is commonly used to describe this training period. At the conclusion of the residency period, some individuals enter an additional year of training as chief resident. Others, particularly in internal medicine, enter a fellowship in one of the discipline's subspecialties. A fellowship usually encompasses a two-or-three-year period, and often includes time for research.

The resident physician is both a learner and a provider of medical care. The resident is involved in caring for patients under the supervision of more experienced physicians. As their training progresses, residents gain competence and require less supervision, progressing from on-site and contemporaneous supervision to more indirect and periodic supervision. Throughout their training, residents also serve as teachers and join with faculty members to educate medical students in hospital settings.

Programs are accredited by the Accreditation Council for Graduate Medical Education (ACGME), which, in turn, acts on the recommendations of 26 Residency Review Committees (RRCs), each of which serves a medical and surgical specialty. Specialty certifying boards establish the educational criteria that residents must achieve to be eligible for board certification. These criteria include the length of time for education and training and, to a significant degree, the content of the training program. These are detailed in the Special Requirements for each specialty's residency programs and complement the *General Requirements of the Essentials of Accredited Residencies in Graduate Medical Education* promulgated by the ACGME.

Mary Hitchcock Memorial Hospital (MHMH), as part of Dartmouth-Hitchcock Medical Center, assumes accountability for the quality of the GME training programs it sponsors. While each program assumes responsibility to ensure integrity under the purview of each RRC, institutional oversight is maintained by the MHMH Graduate Medical Education Advisory Committee (GMEAC). The GMEAC is comprised of all program directors and has representation from the Department of Nursing, Administration, program coordinators, and house staff. The Committee meets monthly except in July and August. The GME Office (hereafter in this manual referred to as GME) implements institutional policies and procedures approved by the GMEAC. GME maintains house-staff and accreditation records, facilitates internal reviews of educational programs, serves as liaison with the ACGME, coordinates benefit programs for house staff, and supports the administration of individual programs.

Statement of Commitment to Graduate Medical Education

The Dartmouth-Hitchcock Medical Center is made up of four components: Mary Hitchcock Memorial Hospital, Dartmouth Medical School, Dartmouth-Hitchcock Clinic and the Veterans Administration Medical Center. Mary Hitchcock Memorial Hospital has sponsored Graduate Medical Education programs since 1895 and is the sponsoring institution of GME accredited training programs.

The Mary Hitchcock Memorial Hospital Board of Trustees recognizes their institutional commitment by provision of the leadership, organization, educational environment, adequate human resources and a sound

budgeted fiscal plan for GME teaching faculty, program directors and house staff in order to provide a high quality graduate medical education training experience.

ACGME Competencies

MHMH is committed to providing house staff with an educational environment that allows a resident or fellow to demonstrate to the satisfaction and understanding of the faculty, the following attributes and objectives as proposed by the ACGME.

Each residency program enables its residents to develop competencies in six areas. Toward this end, programs define the specific knowledge, skills, and attitudes required, and provide educational experiences as needed, in order for their residents to demonstrate the competencies.

Beginning July 1, 2006, and continuing through June 2011, DHMC training programs will integrate these competencies into written curriculum and evaluations related to education and clinical care. Programs will use resident performance data as the basis for program improvement and provide evidence for accreditation review. Programs will begin to use external measures e.g., clinical quality indicators, patient surveys, employer evaluations of graduates, national and specialty standardized measures) to verify resident and program performance levels.

Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. *Residents are expected to:*

1. Communicate effectively and demonstrate caring and respectful behavior when interacting with patients and their families.
2. Gather essential and accurate information about their patients.
3. Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment.
4. Develop and carry out patient management plans.
5. Counsel and educate patients and their families.
6. Use information technology to support patient care decisions and patient education.
7. Perform competently all medical and invasive procedures considered essential for the area of practice.
8. Provide health care services aimed at preventing health problems and maintaining health.
9. Work with health care professionals, including those from other disciplines, to provide patient-focused care.

Medical Knowledge

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. *Residents are expected to:*

1. Demonstrate an investigatory and analytic thinking approach to clinical situations.
2. Know and apply the basic and clinically supportive sciences which are appropriate to their discipline.

Practice-based Learning and Improvement
Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. *Residents are expected to:*

1. Analyze practice experience and perform practice-based improvement activities using a systematic methodology.
2. Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.
3. Obtain and use information about their own population of patients and the larger population from which their patients are drawn.
4. Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
5. Use information technology to manage information, access online medical information, and support their own education.
6. Facilitate the learning of students and other health care professionals.

Interpersonal and Communication Skills
Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families, and professional associates. *Residents are expected to:*

1. Create and sustain a therapeutic and ethically sound relationship with patients.
2. Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills.
3. Work effectively with others as a member or leader of a health care team or other professional group.

Professionalism
Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. *Residents are expected to:*

1. Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supercedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development.
2. Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices.
3. Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities.

Systems-Based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. *Residents are expected to:*

1. Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice.
2. Know how types of medical practice and delivery systems differ from one another, including methods of controlling health-care costs and allocating resources.
3. Practice cost-effective health care and resource allocation that does not compromise quality of care.

4. Advocate for quality patient care and assist patients in dealing with system complexities.
5. Know how to partner with health-care managers and health-care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

Source: *ACGME Outcome Project*

Physician Attributes and Educational Objectives

MHMH affirms the Association of American Medical Colleges (AAMC) Medical School Objectives Project (MSOP). Although initially designed with a focus on undergraduate medical education, the project has expanded to encompass GME. MSOP outlines objectives to address the central question: What knowledge, skills, attitudes, and values should medical students and residents be expected to demonstrate? The objectives are summarized as follows, and serve as a core for GME programming at MHMH:

Physicians Must Be Altruistic

- Knowledge of the theories and principles that govern ethical decision-making and of the major ethical dilemmas in medicine, particularly those that arise at the beginning and end of life and those that arise from the rapid expansion of knowledge of genetics.
- Compassionate treatment of patients, with respect for their privacy and dignity.
- Honesty and integrity in all interactions with patients' families, colleagues, and others with whom physicians must interact in their professional lives.
- An understanding of, and respect for, the roles of other health care professionals and the need to collaborate with others in caring for individual patients, while promoting the health of defined populations.
- A commitment to advocate at all times the interests of one's patients over one's own interests.
- An understanding of the threats to medical professionalism posed by the conflicts of interest inherent in various financial and organizational arrangements for the practice of medicine.
- The capacity to recognize and accept limitations in one's knowledge and clinical skills, and a commitment to continuously improve one's knowledge and ability.

Physicians Must Be Knowledgeable

- Knowledge of the normal structure and function of the body (as an intact organism) and of each of its major organ systems.
- Knowledge of the molecular, biochemical, and cellular mechanisms that are important in maintaining the body's homeostasis.
- Knowledge of the various causes (genetic, developmental, metabolic, toxic, microbiologic, autoimmune, neoplastic, degenerative, and traumatic) of maladies and the ways in which they operate on the body (pathogenesis).
- Knowledge of the altered structure and function (pathology and pathophysiology) of the body and its major organ systems that are seen in various diseases and conditions.
- An understanding of the power of the scientific method in establishing the causation of disease and efficacy of traditional and nontraditional therapies.
- An understanding of the need to engage in lifelong learning to stay abreast of relevant scientific advances, especially in the disciplines of genetics and molecular biology.

Physicians Must Be Skillful

- The ability to obtain an accurate medical history that covers all essential aspects of the history, including issues related to age, gender, and socioeconomic status.

- The ability to perform both a complete and an organ-system-specific examination, including a mental status examination.
- The ability to perform routine technical procedures including, at a minimum, venipuncture, inserting an intravenous catheter, arterial puncture, thoracentesis, lumbar puncture, inserting a nasogastric tube, inserting a Foley catheter, and suturing lacerations.
- The ability to interpret the results of commonly used diagnostic procedures.
- Knowledge of the most frequent clinical, laboratory, roentgenologic, and pathologic manifestations of common maladies.
- The ability to reason deductively in solving clinical problems.
- The ability to construct appropriate management strategies (both diagnostic and therapeutic) for patients with common conditions, both acute and chronic, including medical, psychiatric, and surgical conditions, and those requiring short- and long-term rehabilitation.
- The ability to recognize patients with immediately life-threatening cardiac, pulmonary, or neurological conditions regardless of etiology, and to institute appropriate initial therapy.
- The ability to recognize and outline an initial course of management for patients with serious conditions that require critical care.
- Knowledge about relieving pain and ameliorating the suffering of patients.
- The ability to communicate effectively, both orally and in writing, with patients, patients' families, colleagues, and others with whom physicians must exchange information in fulfilling their responsibilities.

Physicians Must Be Dutiful

- Knowledge of the important non-biological determinants of poor health and of the economic, psychological, social, and cultural factors that contribute to the development and/or continuation of maladies.
- Knowledge of the epidemiology of common maladies within a defined population, and the systematic approaches useful in reducing the incidence and prevalence of those maladies.
- The ability to identify factors that place individuals at risk for disease or injury, to select appropriate tests for detecting patients at risk for specific diseases or in the early stage of disease, and to determine strategies for responding appropriately.
- The ability to retrieve (from electronic databases and other resources), manage, and use biomedical information for solving problems and making decisions that are relevant to the care of individuals and populations.
- Knowledge of various approaches to the organization, financing, and delivery of health care.
- A commitment to provide care to patients who are unable to pay and to advocate for access to health care for members of traditionally underserved populations.

Source: *AAMC Medical School Objectives Project)*

GME Competencies

In support of learning consistent with the ACGME Competencies and the AAMC Medical Schools Objectives Project, cross-program elective educational opportunities sponsored by the GME Office supplement events organized by individual training programs. During the 2207-2008 training year opportunities will include:

- GME Grand Rounds
- Biomedical Libraries Workshops and Grand Rounds
- Videoconferences
- Independent Study Electives

In addition, the GME Office in partnership with the Biomedical Libraries maintains a video collection of conferences, workshops, and grand rounds appropriate to support learning consistent with the General Competencies. Video kits are on seven-day circulation reserve at the Matthews-Fuller Library Circulation Desk, DHMC 5th Level.

II. Program Eligibility and Selection Process

Eligibility Requirements for MHMH GME Accredited Residency and Fellowship Programs

Applicants must meet <u>one</u> of the following qualifications to be eligible for appointment to ACGME-accredited residency and fellowship programs at DHMC:

1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME) and successful completion of any pre-requisite accredited training specified by ACGME Residency Review Committees. Some programs require successful passage of board exams (or good faith effort to pass) for promotion through subsequent years of fellowship.

2. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA) and successful completion of any pre-requisite accredited training specified by ACGME Residency Review Committees.

3. Graduates of medical schools outside the United States and Canada who meet the following qualifications:

    a. Have a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment or,

    b. Have a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are in training and,

    c. Successful completion of any pre-requisite accredited training specified by ACGME Residency Review Committees.

4. Graduates of medical schools outside the United States who have completed a Fifth Pathway program* provided by an LCME-accredited medical school and successful completion of any pre-requisite accredited training.

    * A Fifth Pathway program is an academic year of supervised clinical education provided by an LCME-accredited medical school to students who meet the following conditions: (1) have completed, in an accredited college or university in the United States, undergraduate premedical education of the quality acceptable for matriculation in an accredited United States medical school; (2) have studied at a medical school outside the United States and Canada but listed in the World Health Organization Directory of Medical Schools; (3) have completed all of the formal requirements of the foreign medical school except internship and/or social service; (4) have attained a score satisfactory to the sponsoring medical school on a screening examination; and (5) have passed either the Foreign Medical Graduate Examination in the Medical Sciences, Parts I and II of the examination of the National Board of Medical Examiners, or Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).

Additionally, applicants must meet all of the following requirements:

1. Applicant must be eligible to obtain a Training License.

    a. The New Hampshire Board of Medicine requires demonstration of passing scores on one of the following sets of examinations:

- USMLE Steps 1 and 2 CK, CS
- COMLEX Level 1 and 2 CE, PE
- NBME Parts 1 and 2
- FLEX Parts I and II
- NBOE Parts I and II
- LMCC

b. Foreign medical graduates must also supply verification of ECFMG Certification.

It is recommended that you have passed these examinations and/or obtained ECFMG Certification no later than January 1st of the year in which there is an anticipated June or July residency start date. It is imperative that applicants meet these requirements in order to be appointed and begin training on time.

Note: NH Training licenses shall be confined to activities performed in the course of the qualifying residency or graduate fellowship training program, shall expire automatically upon the licensee's separation from the residency or graduate fellowship training program for any reason, and may be issued on a restricted or conditional basis.

2. Non-citizens must have Permanent Resident Status, Employment Authorization Card or be eligible to obtain the appropriate visa as outlined in the DHMC Graduate Medical Education Visa Policy.

3. Applicant must be fully competent in written and oral English.

4. Applicant must be willing and able to appear for an interview, if invited.

5. Applicant must have successfully completed any pre-requisite accredited training specified by the ABMS or an ACGME RRC.

Selection Process for MHMH GME Accredited Residency and Fellowship Programs

It is the policy of Mary Hitchcock Memorial Hospital at Dartmouth-Hitchcock Medical Center to sustain house staff selection processes that are free from impermissible discrimination. In compliance with all federal and state laws and regulations, no person shall be subject to discrimination in the process of house staff selection on the basis of race, national origin, gender, religion, age disability, marital or parental status, status as a Vietnam-era veteran, sexual orientation, or gender identity.

Selection of House Staff

1. Applications, along with required supporting documentation, are submitted according to the appropriate procedure outlined on the Program web page (ie: Submission of paper application or via Electronic Residency Application Service.)

2. Applicants meeting eligibility requirements outlined by the Institution and the Program will be invited for a personal interview. Interview days include (but are not limited to) interviews with faculty and house staff, program orientations, tours of the medical center, attendance at conferences, etc.

3. Each program will apply its own criteria for evaluating and ranking candidates. That criteria may include, but is not limited to:

    a. Review and confirmation of eligibility requirements

b. Performance on standardized medical knowledge test.
c. Verbal and written communication skills.
d. Letters of recommendation from faculty.
e. Dean's letter.
f. Medical school transcript.
g. A commitment to complete the entire training program.

The recruitment and appointment of residents and fellows to training programs sponsored by Mary Hitchcock Memorial Hospital is based on and in compliance with the institutional, common and specific program requirements of the Accreditation Council for Graduate Medical Education (ACGME). The process of application, eligibility, selection and appointment of residents or fellows to a program is the responsibility of the Department Chairperson, the Program Director, and/or departmental faculty.

Mary Hitchcock Memorial Hospital presently has no pre-employment drug testing policy, however one will be implemented for all new residents and fellows hired for the academic year 2009-2010.

Mary Hitchcock Memorial Hospital currently has no requirement that residents must sign a non-competition clause as part of the Resident/Fellow Agreement of Appointment.

MHMH Graduate Medical Education Visa Policy

Non-citizens, in addition to meeting eligibility requirements set forth in the Graduate Medical Education Accredited Residency and Fellowship Program Eligibility Requirement policy must either have Permanent Resident Status, an Employment Authorization Card or be eligible to obtain an employment visa as outlined in the following policy.

All eligible fees related to obtaining appropriate visa or work authorization status including USMLE transcripts or other examination credentialing, licensure and or legal fees are the full responsibility of the applicant or resident or fellow.

Visa Categories

J-1

The J-1 visa is a temporary nonimmigrant visa reserved for participants in the Exchange Visitor Program. As a public diplomacy initiative of the U.S. Department of State, the Exchange Visitor Program was established to enhance international exchange and mutual understanding between the people of the United States and other nations. In keeping with the Program's goals for international education, J-1 exchange visitor physicians are required to return home for at least two years following their training before being eligible for certain U.S. visas.

The Educational Commission for Foreign Medical Graduates (ECFMG) is authorized by the U.S. Department of State (DOS) to sponsor foreign national physicians as Exchange Visitors in accredited programs of graduate medical education or training or advanced research programs (involving primarily observation, consultation, teaching or research). Exchange Visitors sponsored by ECFMG receive a Certificate of Eligibility for Exchange Visitor (J-1 Visa) Status (Form DS-2019). This document is used to apply for the J-1 visa.

Foreign national physicians seeking J-1 sponsorship to enroll in programs of graduate medical education (GME) or training in the United States must fulfill a number of general requirements, which are detailed in the application materials. At a minimum, applicants must:

1. Have passed Step 1 and Step 2 Clinical Knowledge (CK) of the United States Medical Licensing Examination™ (USMLE™) [and/or an acceptable combination of components of the former *Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS), the National Board of Medical Examiners® (NBME®) Part sequence, or the Visa Qualifying Examination (VQE)];

   *The NH Board of Medicine does not recognize the former FMGEMS examinations. Please see the Graduate Medical Education Accredited Residency and Fellowship Program Eligibility Requirements for a listing of acceptable licensing exams.

2. Hold a valid Standard ECFMG Certificate at commencement of training;

3. Hold a contract or an official letter of offer for a position in a program of graduate medical education or training that is affiliated with a medical school;

4. Provide a Statement of Need from the Ministry of Health of the country of most recent legal permanent residence, regardless of country of citizenship. This statement provides written assurance that the country needs physicians trained in the proposed specialty and/or subspecialty. It also serves to confirm the applicant physician's commitment to return to that country upon completion of training in the United States, as required by Section 212(e) of the Immigration and Nationality Act, as amended.

F-1 OPT

An F-1 student is a nonimmigrant who is pursuing a full course of study towards a specific educational or professional objective, at an academic institution in the United States that has been designated by the Immigration and Naturalization Service (INS) to offer courses of study to such students.

The "Citizenship and Immigration Services" (CIS) may authorize students in F-1 status to engage in "optional practical training" (OPT) for up to 12 months after completion of studies, provided the appointment can be completed in 12 months. This OPT authorization is appropriate for the first or matched year, which is a 1-year contract. International Medical Graduates who receive US medical degrees while in F-1 status may apply to the CIS for OPT work authorization.

If the CIS grants employment authorization, the individual may use that authorization for residency education for a period of *12 months. The F-1 "designated school official" (DSO) at the US medical school can usually provide information necessary to make employment eligibility determinations for these graduates.

Pending meeting program requirements, students engaged in OPT for 12 months could be sponsored for further training under the H-1B visa status.

H-1B Transfer

The H visa category is for the temporary employment or training of foreign nationals by a specific employer. The H-1B visa allows professional foreign physicians to work in the US in specialty occupations for up to six years.

Programs may consider candidates who are presently holding H-1B visas from other training programs. Each training program will apply certain program specific criteria for screening of H-1B applicants. The program then will present these candidates to the GME Office for final approval.

There are several basic requirements physicians must meet to enter into an H-1B status to perform clinical medicine, including the following.

1. Have a license or other authorization required by the state where they will practice
2. Have an unrestricted license to practice medicine in a foreign country or have graduated from a foreign or U.S. medical school; and
3. Have passed the *appropriate licensing examinations.

*The USMLE has become the exclusive examination for over 12 years. Passage of some earlier examinations is still recognized, but "mixing and matching" parts of different examinations is not permitted for H-1B purposes. Please refer to the Graduate Medical Education Accredited Residency and Fellowship Program Eligibility Requirements for a listing of acceptable licensing examinations.

ECFMG Certification

The Educational Commission for Foreign Medical Graduates (ECFMG), through its program of certification, assesses whether international medical graduates are ready to enter residency or fellowship programs in the United States that are accredited by the Accreditation Council for Graduate Medical Education (ACGME).

ECFMG and its organizational members define an international medical graduate as a physician who received his/her basic medical degree or qualification from a medical school located outside the United States and Canada. To be eligible for ECFMG Certification, the physician's medical school and graduation year must be listed in the *International Medical Education Directory (IMED)* of the Foundation for Advancement of International Medical Education and Research (FAIMER). To verify that a particular medical school and graduation year are listed, access *IMED*.

Citizens of the United States who have completed their medical education in schools outside the United States and Canada are considered international medical graduates; non-U.S. citizens who have graduated from medical schools in the United States and Canada are not considered international medical graduates.

ECFMG Certification assures directors of ACGME-accredited residency and fellowship programs, and the people of the United States, that international medical graduates have met minimum standards of eligibility required to enter such programs. ECFMG Certification does not, however, guarantee that these graduates will be accepted into programs, since the number of applicants frequently exceeds the number of available positions.

ECFMG Certification is one of the eligibility requirements for international medical graduates to take Step 3 of the three-step United States Medical Licensing Examination (USMLE). Medical licensing authorities in the United States require ECFMG Certification, among other requirements, to obtain an unrestricted license to practice medicine.

For information about **certification requirements, examination requirements, medical education credentials,** etc, please refer to the ECFMG 2007 Information Booklet, available on-line in PDF format.

III. House Staff Orientation, Resident Agreement, Stipends and Benefits

Mandatory GME Orientation

All new Residents and Fellows are required to attend GME Orientation before beginning the training year. Orientation is June 24th and 25th as well as July 1st and 2nd.

The June 24th and 25th Orientation is generally for first year residents.

The July 1st and 2nd Orientation is generally for second year residents up through Fellow level appointments.

Attendance during both days of the assigned session is mandatory. Programs will conduct individual orientations on separate dates.

**House staff beginning their training year off-cycle as well as visiting house staff from other institutions, must complete a GME orientation before they are allowed to begin training and provide patient care. Off-cycle and visiting orientations typically consist of attendance at the institutional general orientation, MD C.I.S. class and an occupational medicine pre-employment screening in addition to several other appointments usually scheduled over the course of the first two days of employment or visit.

Stipend Level Policy

Stipend levels are paid commensurate with the responsibility of training position. All house staff in the same Program Level will be paid at the same Stipend Level. Only Board eligibility and ACGME prerequisite years of training for the current training program are applicable towards the Stipend Level. Incentive pay for house staff joining any training program is not allowed. (This policy was approved by GMEAC September 18, 1997.)

GME Stipend Levels

Post-Graduate Year	Stipend Level
PGY 1	$45,860
PGY 2	$48,360
PGY 3	$51,070
PGY 4	$53,500
PGY 5	$56,280
PGY 6	$58,995
PGY 7	$61,625
PGY 8	$64,085

SAMPLE RESIDENT/FELLOW AGREEMENT OF APPOINTMENT

This Agreement of Appointment is entered into between_____, **MD/DO** and Mary Hitchcock Memorial Hospital for graduate training as a **Resident/Fellow in** _____ at the **PGY** ____ **Level** to engage in graduate medical education or training, pending successful appropriate certification from the USMLE, NBME and/or ECFMG by the agreement start date. Both parties agree to their respective ethical and legal obligations and have entered into this Agreement in good faith. This Agreement shall be in effect from _____ through _____, at the **stipend level of** _____ per year as long as resident performance is satisfactory within the terms of this Agreement. Ability to be accepted and appointed for training is contingent upon meeting all DHMC and ACGME Eligibility Requirements, remaining eligible for a training license, ability to function at the agreed upon level, and being physically present and medically able to begin and continue training on the agreed upon date in this mutually signed GME Resident-Fellow Agreement of Appointment, and pending obtaining the appropriate training visa if applicable.

Mary Hitchcock Memorial Hospital agrees to provide a resident training program that meets the requirements of the Accreditation Council on Graduate Medical Education. The resident/fellow agrees to perform his/her duties to the best of his/her ability, and to abide by applicable hospital and medical staff rules and regulations and provide safe, effective and compassionate patient care.

Information regarding resident/fellow compensation, including stipend and benefits, vacation policies, sick leave, professional liability that includes coverage for claims arising out of medical incidents occurring during the period of participation in the program, disability insurance and health insurance for residents and their families, leave of absence benefits that include parental and professional leave, conditions for call room, living quarters, meals and laundry, counseling, medical, psychological and other support services, and related program policies, including moonlighting, successful completion of the program, Fair Hearing and Concern Policies, sexual or other harassment, House Staff Association, and residency closure or reduction of program, are enclosed in the GME Red Book and are considered to be part of this Agreement.

As terms of this Agreement, the resident/fellow agrees that:

A. He/she will perform all duties and accept all reasonable assignments designated by the Program Director and/or his/her designee. Performance will be evaluated periodically by program director and/or departmental chair. Reappointment will be dependent upon satisfactory evaluations and fulfillment of program and institutional requirements and availability of positions.

B. He/she will fulfill the obligations set forth in this Agreement and comply with, and be subject to, all other applicable hospital policies and medical staff by-laws; rules and regulations; state, federal and local laws; and standards required to maintain accreditation by relevant accrediting, certifying, or licensing organizations, including maintaining a valid training or permanent New Hampshire license throughout duration of this Agreement.

C. He/she will return all hospital properties such as books and equipment; complete all records; and settle his/her professional and financial obligations prior to departure from the residency program.

The Resident/Fellow training at Mary Hitchcock Memorial Hospital is also expected to:

A. Develop a personal program of study to foster continual professional growth with guidance from the teaching staff.

B. Participate in safe, effective, and compassionate patient care under supervision commensurate with his/her level of advancement and responsibility.

C. Participate fully in the educational and scholarly activities of the program, as required, and assume responsibility for teaching and supervising other residents and students.

D. Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures, and policies of the institution.

E. Become involved with institutional committees and councils whose actions affect their education and/or patient care;

F. Apply cost containment measures to the provision of patient care; using program and institutional systems.

G. Submit to program director and/or GME, confidential written evaluations of the faculty and of their educational experiences, duty hours and other requested information and reports in a timely, accurate manner.

Mary Hitchcock Memorial Hospital and through its participating hospital(s) and institution(s) will provide:

A. An accredited educational program that provides for the educational needs of the resident/fellow including the opportunity to acquire the skills, attitudes, and knowledge consistent with proper patient care and meets the ACGME Requirements for the above named training Program.

B. Patient support ancillary services; laboratory, medical records, and radiologic structures appropriate and consistent with quality and timely patient care;

C. Appropriate, readily available supervision;

D. Appropriate stipends and benefits, health and disability insurance including malpractice insurance for duration of training and after for claims reported or filed pertaining to alleged acts or omissions within scope of program;

E. Counseling services;

F. Duty hour policy and schedule consistent with patient safety and the educational, Institutional and Program Requirements that apply to the Program; and

G. Work environment that includes the following conditions:

1. Provision of adequate and appropriate food services and sleeping quarters;
2. Patient support services consistent with educational objectives and patient care;
3. Appropriate security measures.

Mary Hitchcock Memorial Hospital presently has no pre-employment drug testing policy, however one will be implemented for all new residents and fellows hired for the academic year 2009-2010.

Mary Hitchcock Memorial Hospital currently has no requirement that residents must sign a non-competition clause as part of the Resident/Fellow Agreement of Appointment.

Nonrenewal of Agreement of Appointment

A. In the event that it is determined by Responsible Person(s) that renewal of this Agreement for a subsequent year of residency/fellowship will not be made, Mary Hitchcock Memorial Hospital shall use its best efforts to provide resident/fellow written notice of such determination within no less than one hundred twenty (120) days prior to the expiration of this Agreement. If primary reason(s) for non-renewal occur(s) within four months prior to end of Agreement of Appointment, written notice will be provided as circumstances reasonably allow.

B. In the event the resident/fellow intends not to seek renewal of this Agreement for a subsequent year of training, resident/fellow shall use best efforts to furnish the Responsible Person(s) written notice of such intent within no less than one hundred twenty (120) days prior to the expiration of this Agreement. If primary reason(s) for non-renewal occur(s) within four months prior to end of agreement of appointment, written notice will be provided as circumstances reasonably allow.

WITH INTENTION to be legally bound hereby, the Parties have duly executed this Agreement on the date(s) indicated below.

_____ _____

Resident/Fellow Date

_____ _____

John G. Kelleher Date
Administrative Director, Graduate Medical Education

Benefits

Vacation
House staff at all levels are allowed three weeks time off per training year, 15 business days and six weekend days.

On-Call Meals
Call night allowances will be initially distributed in July **to those house staff required to be in the hospital overnight.** The amount is determined by taking your number of in-house calls x the current nightly meal allowance. Your allowance can be used as you wish, but it is designated as call-night allowance and once it is gone, there will be no more until the next training year begins. GME receives a listing of your charges each month. If you feel you were not given enough call night money, please discuss it with your chief resident and have them call GME to discuss any shortages.

***If you have any problems with the hospital cafeteria or Cravin's concerning your meal card, *do not discuss them with the cashiers;* call Graduate Medical Education, 5-5748.**

Coats
Two lab coats are provided to all house staff at the beginning of training, and two additional coats are available each following year. We offer 100% cotton, unisex-sized coats in coat sizes ranging from 30 to 56. Coats are embroidered with the DHMC logo, and name and specialty. Laundry services are provided for coats and scrubs. Laundered coats for house staff are found in the call room kitchen area. Coats not embroidered with a name on them must be marked with **"GME" and last name in permanent laundry marker on the inside collar of their coats, just above the label.** Coats not properly marked will not be returned to the call room, may be lost and will not be replaced by GME.

Parking
Free parking space is available throughout the Hospital premises and off-site locations are provided. Security and Parking maintains shuttle bus services to lots 9, 20, and between DHMC campus sites.

Child Care Center
DHMC has an on-site Child Care Center designed to care for the children of employees and house staff. It includes eight classrooms, two large indoor play areas and two separate outdoor playgrounds. Adjacent to the Medical Center, it can accommodate children from six weeks through five years of age. A highly qualified staff provides professional care from 6:30 AM to 6:00 PM, Monday through Friday. There is a sliding fee scale based upon your income and payroll deduction is available. Those interested in this care should apply as early as possible by calling 603-643-6504.

THE HITCHCOCK FOUNDATION Residents' Revolving Loan Fund
The Hitchcock Foundation established the Residents' Revolving Loan Fund fund in 1959 to assist Residents and Fellows at the Medical Center with emergency or unforeseen expenses. All repayments and interest on loans are returned to the Revolving Loan Fund, thus the Fund and its benefits are perpetuated for future applicants.

Most loan fund applicants already have substantial loan balances related to their education and in some cases additional debt for a car, credit and charge cards. While a loan from the Hitchcock Foundation may be modest by comparison, it is adding to your debt burden and hence your application should be a careful and reasoned decision. It is also and an opportunity to review your current income and expense including debt service.

The Regulations for the Resident's Revolving Loan Fund, a Summary Worksheet of Income and Expense and a Revolving Loan Fund Application can be found at:
http://www.dhmc.org/webpage.cfm?site_id=2&org_id=432&morg_id=0&sec_id=0&gsec_id=19822&item_id=19822 .

If you plan to apply for a loan from the Hitchcock Foundation, your Income and Expense Worksheet must be completely filled out and enclosed with your Application. Those interested in a more detailed income and expense worksheet, please contact Karen Jones at 653-1230.

If you have questions, they should be referred to Karen Jones at (603) 653-1230 or Karen.E.Jones@Hitchcock.ORG. She also has a list of individuals who provide financial counseling should you desire help or require counseling under the terms of the Revolving Loan Fund Regulations.

Completed Applications and your financial summary should be forwarded to The Hitchcock Foundation, Colburn Hill.

Health and Welfare Benefits

The 2005 House Staff Summary Plan Description of the Welfare Benefit Plans for House Staff (SPD) and the 2007 Summary of Material Modifications describes the benefits available to house staff members of GME training programs sponsored by the hospital. Please refer to it for full details of the medical, dental, long term disability, life insurance and flexible spending account benefits highlighted below. If you have questions after reviewing your SPD, please call GME, ext. 5-5748.

Medical Insurance

The House Staff health care plan is an employer paid PPO plan, administered by Anthem BlueCross BlueShield. **Spouses, dependants, domestic partners and their minor children are covered for most services at the $0 (zero) deductible level for in-network services.**

Coverage begins on the date of hire. Coverage continues to the end of the month you finish your training, plus one month, after which you may elect to pay for COBRA coverage or wait until your new medical coverage begins.

Dental Insurance

This voluntary coverage is provided by Northeast Delta Dental. Your portion of the premium will be deducted in 26 parts from your biweekly paychecks. **Coverage begins on the date of hire.**

Life Insurance

All House Staff are insured for one times their stipend, rounded to the next higher $1,000, subject to a maximum of $50,000 through term insurance from The Hartford. Supplemental Life/AD&D is available in increments of .5 times your base salary to a maximum of $500,000 without evidence of insurability, Premiums for this supplemental coverage are the responsibility of the resident/fellow and will be deducted from your bi-weekly paycheck. Dependent Life/AD&D coverage is available for your spouse/dependants, please review the enrollment booklet for specifics on coverage limits and premiums. You will be required to designate your beneficiaries on-line when you enroll in your benefits. You may change your beneficiary at any time during the training year.

Sick Leave

You have 90 days of paid sick leave per training year at your full stipend, through GME. Any illness lasting more than 2 weeks will require a note from your physician and a fit for duty evaluation from Occupational Medicine upon your return.

Long Term Disability

Long-term disability benefits may begin on your 91st day of disability. Application for long-term coverage through The Hartford is recommended by the 60th day of illness if you anticipate being out for more than 90 days due to a qualifying disability.

Medical benefits may be continued for House Staff on approved leaves of absence for up to a total of 12 months beginning from the first day of the leave.

Health Care Reimbursement Program
The Health Care Reimbursement Program (HCRP) is offered under the Flex Plan to provide you with a tax-effective way to pay for medical and dental services outside of the Medical and Dental Plans. Since some health care services are not covered due to deductibles, or other benefit limitations, or only partially covered, employees and dependents usually pay for them out of their own pocket. HCRP establishes a reimbursement account that can be an important part of your annual budget planning as it allows you to set aside funds, before paying taxes which may be used to pay for some or all of these expenses.

Dependent Care Assistance Program
The Dependent Care Assistance Program (DCAP) is offered under the Flex Plan to provide a tax-effective way to pay for dependent care expenses resulting from the employment of an employee and spouse. DCAP allows you to set aside funds, before paying taxes, to cover certain dependent care expenses.

Dartmouth-Hitchcock Malpractice Insurance Coverage & Risk Management Program

Background
The Dartmouth-Hitchcock Clinic (DHC), Mary Hitchcock Memorial Hospital (MHMH), and Dartmouth College (DC/DMS) participate in a self-insured malpractice insurance program that was created in 1977. By pooling financial resources, they are able to obtain professional and comprehensive general liability insurance to cover medical center employees such as physicians (including physicians admitted to professional graduate training programs as residents or fellows), nurses, medical students, other clinical and non-clinical employees, and volunteers. As a Resident or Fellow, you are covered under this insurance program for activities within the scope of your employment. Over the years, the program has been effective from both a risk-funding and a claims-management perspective. The combined program facilitates cooperation among those it insures by utilizing a joint defense of claims. When a claim is asserted against more than one of the institutions and/or its insureds, potentially divisive forces are avoided by coordinating the defense of all co-defendants rather than each institution attempting to minimize its separate liability.

Questions and Answers about Your Coverage and the Risk Management Program

- **What are my responsibilities as an individual insured under the program?**
  As an individual covered under the insurance program, you have several responsibilities, including:
  - Prompt reporting of events to Risk Management
  - Participation in follow-up of events or patient complaints, which may include meeting with a Dartmouth-Hitchcock Risk Manager or our claims management staff from Atlantic Risk Management.
  - Interaction/consultation with Risk Management staff when questions or concerns arise

- **How do I reach Risk Management?**
  Risk Management assistance is available 24/7. The office is on the main DHMC campus on the 2nd floor of the Doctors' Office Building and is open from 8AM – 5PM (Monday – Friday) and you can call us at 603-650-7864. A Risk Manager is also on-call after hours via pager through DHMC Communications.

- **Do I only report adverse events to Risk Management? What about near-misses?**

One of the most useful risk management tools, and one that is sometimes neglected, is the thorough investigation of "near-misses." As any liability claims manager can attest, before a catastrophic event occurs, the same set of circumstances may have been in place multiple times without triggering such an event. Your risk management program encourages the investigation and discussion of "near-misses." This is the best way to address problems related to the idiosyncrasies of a particular institution before a catastrophic event occurs.

- **Do I need to report a bad outcome if it was a known risk/complication which was fully discussed and documented in the informed consent process?**
  Yes. Any loss of function at the time of discharge and any iatrogenic injury that extends the hospital stay, requires additional treatment, or results in readmission (even if the loss or injury is a known risk/complication of the treatment provided) should be reported to Risk Management.

- **What form of malpractice insurance coverage is provided?**
  The Dartmouth-Hitchcock insurance policy is written on a "modified claims-made" basis which means it covers claims or adverse incidents actually reported to the insurance program during the policy year, resulting from services rendered after inception of an employee's coverage under this program. It is "modified" because it also covers the "tail." The primary limits are $1 million per claim and $3 million aggregate.
- **What happens when a Resident or Fellow leaves the program?**
  Residents or Fellows who leave Dartmouth-Hitchcock employ will continue to be covered for the "tail", i.e., claims made subsequent to their departure, but only for covered claims arising out of medical incidents that occurred during the period of the individual's participation in the Dartmouth-Hitchcock insurance program.

- **Will the policy cover me for claims incurred before I began my Residency or Fellowship at MHMH?**
  No. Claims related to a service rendered prior to the individual's employment here should be covered by the insurance carried by that employee at the time the service was rendered. Employees who previously had a claims-made policy from another insurance company should procure appropriate "tail coverage" from that carrier before entering this insurance program. Individuals whose prior policy was an occurrence policy do not need to purchase tail coverage. Check with your prior employer/insurance company if you do not know which type of coverage was provided.

- **Does the insurance program cover me for any eventuality in my practice?**
  The insurance program covers you for allegations brought against you only while you are practicing within the scope of your employment. Activities outside of your employment ("moonlighting") are covered only as described below. Allegations of sexual misconduct, if found to be true, cannot be covered.

- **Are all the institutions that participate in the Dartmouth-Hitchcock Alliance insured under the Dartmouth-Hitchcock insurance program?**
  No. Check with the Dartmouth-Hitchcock Risk Management Program to verify whether a particular institution is covered by the insurance program. This is especially important if you are considering moonlighting.

- **Are Residents or Fellows covered while "moonlighting" at other institutions that are insured under the program?**
  A Resident or Fellow can be covered under the policy while moonlighting within the Dartmouth-Hitchcock organization, or at a Dartmouth-Hitchcock Alliance institution that is currently insured under our insurance program, so long as he/she (1) has written permission from the Director or Assistant Director of Graduate

Medical Education (GME) for the particular moonlighting activity and (2) GME has notified the Dartmouth-Hitchcock Risk Management Program of this approval in advance of the activity.

- **Are Residents or Fellows covered while "moonlighting" at institutions that are not insured under the program?**
  No. A Resident or Fellow is not covered while moonlighting outside the Dartmouth-Hitchcock organization, or outside of a Dartmouth-Hitchcock Alliance institution that is currently insured under our insurance program. It is important that anyone contemplating moonlighting makes sure they have adequate professional liability coverage, either through the other institution or by their own purchase of an individual policy.

Please be aware that this document is not the actual insurance policy. To review the complete terms and conditions of this program please contact the Executive Director, Dartmouth-Hitchcock Risk Management Program at 603-650-7864.

House Staff Association

The House Staff Association comprises all house staff in GME-accredited training programs at Dartmouth-Hitchcock Medical Center. The purpose of the Association is to provide house staff representation as it pertains to the Institution. The House Staff Association is provided equal representation at the GME Advisory Committee meetings. It organizes extracurricular activities, provides advocacy for residents in matters of grievances and due process, shares and exchanges information, and responds to administration about proposals that might affect house staff.

The House Staff Association elects Officers to an Executive Committee on an annual basis. They are representative on committees including the GME Advisory Committee, the GME Curriculum Committee and the Social Committee.

IV. Position Descriptions, Duty Hours, Call and Evaluations

Position Description for Resident and Fellow Physicians

The position of resident or fellow physician entails provision of patient care matching with the individual physician's level of advancement and competence. Residency is the phase of formal medical education beginning at graduation from medical school and ending after the educational requirements for the medical specialty certifying board has been completed. A resident physician's responsibilities include patient care activities within the scope of his/her clinical privileges commensurate with the level of training, attendance at clinical rounds and seminars, timely completion of medical records, and other responsibilities as assigned or as required of all members of the medical staff. Under the supervision of attending physicians, general responsibilities of the resident physician may include:

- Initial and ongoing assessment of patient's medical, physical, and psychosocial status.
- Perform history and physical.
- Develop assessment and treatment plan.
- Perform rounds.
- Record progress notes.
- Order tests, examinations, medications, and therapies.
- Arrange for discharge and after care.
- Write / dictate admission notes, progress notes, procedure notes, and discharge summaries.
- Provide patient education and counseling covering health status, test results, disease processes, and discharge planning.
- Perform procedures.
- Assist in surgery.

A: Purpose and Scope

[Specialty definition and description from Green Book program requirements.]

The objective for this [specialty specific training period] months of supervised graduate medical education of supervised graduate medical education is to prepare the resident physician for the independent practice of [name of specailty] medicine under the watchful eye of attending faculty clinicians and includes:

a. participation in safe, effective and compassionate patient care;

b. developing an understanding of ethical, socioeconomic and medical-legal issues that affect graduate medical education, and how to apply cost containment measures in the provision of patient care;

c. participation in the educational activities of the training program, and as appropriate, assumption of responsibility for teaching and supervising other residents and students, and participation in institutional orientation and education programs and other activities involving the clinical staff;

d. participation in institutional committees and councils to which the house staff physician is appointed or invited; and

e. performance of these duties in accordance with the established practices, procedures and policies of the institution, and those of its programs, clinical departments and other institutions to which the house staff physician is assigned; including, among others, state licensure requirements for physicians in training.

B. Graded Responsibilities

The resident physician is both a learner and a provider of medical care. The resident physician is involved in caring for patients under the supervision of more experienced physicians. As their training progresses, resident physicians are expected to gain competence and require less supervision, progressing from on-site and contemporaneous supervision to more indirect and periodic supervision.

Resident physicians are given progressive responsibility for the care of the patient. The determination of a resident physician's ability to provide care to patients without a supervisor present or act in a teaching capacity are based on formative evaluations and summative evaluations of the resident physician's clinical experience, judgment, knowledge, and technical skill. These evaluations follow institutional guidelines and align resident physician learning in relation to the general competencies of medical knowledge, patient care, practice-based learning, interpersonal and effective communication, professionalism, and systems-based practice.

Ultimately, it is the decision of the staff practitioner with direct responsibility of the resident as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient that is the responsibility of the staff practitioner.

Both formal examinations and performance ratings by the faculty are utilized, and the resident physician is personally apprised of his or her strengths and weaknesses at appropriate intervals at least twice annually. Completion by the program director of resident yearly report forms is an important part of this evaluation process.

The Residency Program Director has the responsibility to determine that the resident physician possesses the skills necessary to practice at the level commensurate with their training. Annually, at the time of promotion, or more frequently as appropriate, this document will be provided to the Department Chair, the GME Director (institutional DIO), Residency Program Coordinator or Administrator, and into the residency program's records.

C. Organizational Relationships and Supervision

All resident physicians are supervised by licensed independent practitioners who are faculty members practicing at DHMC or affiliated institution.

The resident physician shall participate in patient care under the direction of physicians whose clinical privileges are appropriate to the activities in which the resident physician is engaged. Neither the resident physician's clinical privileges nor his/her clinical responsibilities shall exceed in scope those of his/her supervising physician. The supervising physician shall make clinical assignments to each assigned resident physician consistent with the resident physician's experience and demonstrated clinical competence, and strive to ensure that each resident physician performs assigned duties in an appropriate manner. Resident physicians shall be responsible in their clinical activities to the Chief of the designated Section and through the Chief to the Clinical Department Chair. Except for admitting privileges, the privileges of each resident physician are

determined by the appropriate Section members and Department Chair in context of the respective professional graduate training program requirements

General supervision is provided by appropriately privileged teaching staff. This supervision is proximal, continual, and based on normative and summative evaluations following institutional guidelines. All resident care is supervised and the attending physician is ultimately responsible for care of the patient. The proximity and timing of supervision, as well as the specific tasks delegated to the resident physician depend on a number of factors, including:

a. the level of training (i.e., year in residency) of the resident
b. the skill and experience of the resident with the particular care situation
c. the familiarity of the supervising physician with the resident's abilities
d. the acuity of the situation and the degree of risk to the patient

Outpatient Clinics: Resident physicians in all outpatient clinics are supervised by attending faculty members on-site. Resident physician clinics are held in designated areas (or the same practice area as the faculty practice) and are supported in the areas of nursing, laboratory and other services in the same manner as the faculty practice settings.

Inpatient Settings at Night and on Weekends: Faculty members are available at DHMC 24 hours per day (or generally present in-house but always available by telephone at all times). A faculty member will customarily see any complex or seriously ill patient promptly after admission. Immediate specialty consultations by attending faculty are available on-call at all times to resident physician staff in the same manner that is available to any active member of the medical staff. All patients admitted by resident physicians are reviewed by faculty. In the case of critically ill patients, a treatment plan is usually initiated by an attending staff member and/or consultants in the Emergency Room prior to transfer to the critical care units.

Emergency Room: Resident physicians are supervised by full time emergency room faculty 24 hours per day. The faculty members are responsible for demonstrating and instructing resident physicians in proper emergency patient managements. They supervise the clinical activity of the resident physician and assume the responsibility for evaluating the resident physician's clinical competence and delegating increasing patient care responsibilities as appropriate.

Quality Assurance: All residency programs participate in the medical center-wide quality assurance system. Performance evaluations of residents are coordinated and administered by Residency Program Directors (staff physicians within a particular specialty). Performance evaluations are reflective of both academic knowledge and patient care/clinical skills. These evaluations are considered to be confidential and privileged (by New Hampshire law RSA 151:13a). The ultimate goal of a performance evaluation is to determine if a resident physician's skill, knowledge and experience is sufficient to provide quality care to patients in the future.

JOB REQUIREMENTS:

A. Education and Training

An applicant who has successfully completed Steps 1 & 2 of the USMLE, ***and*** who meets one of the following qualifications, is eligible for appointment as a resident physician to the staff of an accredited DHMC residency program:

1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
2. Graduates of medical schools in the United States accredited by the American Osteopathic association (AOA).
3. Graduates of medical schools outside the United States and Canada who meet the following qualifications:

    a. Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates; ***or***
    b. Have a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction; ***and***
    c. Have possession of, or the ability to obtain, either an exchange visitor or immigrant visa (non-USA citizens only); ***and are***
    d. Fully competent in written and oral English; ***and are***
    e. Willing and able to appear for a personal interview.

4. In order to participate in an accredited Graduate Medical Education clinical training program at DHMC, foreign national physicians must seek ECFMG sponsorship as a J-1 exchange visitor. The objectives of the Exchange Visitor Program are to enhance international exchange and to promote mutual understanding between the people of the United States and other nations through the interchange of persons, knowledge, and skills.

5. United States citizen graduates from medical schools outside the United States and Canada who cannot qualify under Eligibility paragraph 3, but who have successfully completed the licensure examination in a USA. jurisdiction in which the law or regulations provide that a full and unrestricted license to practice will be granted without further examination after successful completion of a specified period of graduate medical education.

6. Graduates of medical schools in the United States and its territories not accredited by the Liaison Committee on Medical Education but recognized by the educational and licensure authorities in a medical licensing jurisdiction who have completed the procedures described in paragraph 4.

7. Graduates of medical schools outside the USA who have completed a Fifth Pathway program provided by an LCME-accredited medical school.

B. Technical Requirements

The resident physician must be in possession of a NHMED license, a DEA and a current BLS certificate (plus other advanced competencies as deemed necessary for their level of training, ACLS, ATLS, PALS, etc.) to become involved in direct patient care.

Resident Duty Hours and Supervision

Evaluation and Supervision of Residents

Each MHMH residency program utilizes measures to assess residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Mechanisms are developed and updated to provide regular and timely performance feedback to residents. This process involves the use of assessment results to achieve progressive improvements in residents' competence and performance consistent with graduated roles and responsibilities as assigned.

The objective for supervised graduate medical education is to prepare the resident physician for the independent practice of medicine and includes:

a. Participation in safe, effective and compassionate patient care;
b. Developing an understanding of ethical, socioeconomic and medical-legal issues that affect graduate medical education, and how to apply cost containment measures in the provision of patient care;
c. Participation in the educational activities of the training program, and as appropriate, assumption of responsibility for teaching and supervising other residents and students, and participation in institutional orientation and education programs and other activities involving the clinical staff;
d. Participation in institutional committees and councils to which the house staff physician is appointed or invited; and
e. Performance of these duties in accordance with the established practices, procedures and policies of the institution, and those of its programs, clinical departments and other institutions to which the house staff physician is assigned; including, among others, state licensure requirements for physicians in training.

The resident physician is both a learner and a provider of medical care. The resident physician is involved in caring for patients under the supervision of more experienced physicians. As their training progresses, resident physicians are expected to gain competence and require less supervision, progressing from on-site and contemporaneous supervision to more indirect and periodic supervision.

Resident physicians are given progressive responsibility for the care of the patient. The determination of a resident physician's ability to provide care to patients without a supervisor present or act in a teaching capacity includes formative and summative evaluations of the resident physician's clinical experience, judgment, knowledge, and technical skill. These evaluations follow institutional guidelines and align resident physician learning in relation to the general competencies of medical knowledge, patient care, practice-based learning, interpersonal and effective communication, professionalism, and systems-based practice.

Ultimately, it is the decision of the Program Director and attending physician with direct responsibility of the resident as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient.

Both formal examinations and performance evaluations by the faculty are utilized, and the resident physician is personally apprised of his or her strengths and weaknesses at appropriate intervals at least twice annually.

Completion by the program director of resident yearly report forms is an important part of this evaluation process.

The Residency Program Director has the responsibility to determine that the resident physician possesses the skills necessary to practice at the level commensurate with their training. Annually, at the time of promotion, or more frequently, appropriate documentation will be provided to the Department Chair, the GME Director (Designated Institutional Official), Residency Program Coordinator or Administrator, and into the residency program's records.

Licensed independent practitioners who are faculty members practicing at DHMC or affiliated institution are among those who supervise all resident physicians.

The resident physician shall participate in patient care under the direction of physicians whose clinical privileges are appropriate to the activities in which the resident physician is engaged. Neither the resident physician's clinical privileges nor his/her clinical responsibilities shall exceed in scope those of his/her supervising physician. The supervising physician shall make clinical assignments to each assigned resident physician consistent with the resident physician's experience and demonstrated clinical competence, and strive to ensure that each resident physician performs assigned duties in an appropriate manner. Resident physicians shall be responsible in their clinical activities to the Chief of the designated Section and through the Chief to the Clinical Department Chair. Except for admitting privileges, the responsibilities of each resident physician are determined by the appropriate Section members and Department Chair in context of the respective professional graduate training program requirements.

General Supervision is provided by appropriately privileged teaching staff. This supervision is proximal, continual, and based on normative and summative evaluations following ACGME and institutional guidelines. All resident care is supervised and the attending physician is ultimately responsible for care of the patient. The proximity and timing of supervision, as well as the specific tasks delegated to the resident physician depend on a number of factors, including:

- the level of training (i.e., year in residency) of the resident
- the skill and experience of the resident with the particular care situation
- the familiarity of the supervising physician with the resident's abilities
- the acuity of the situation and the degree of risk to the patient

Outpatient Clinics: Resident physicians in all outpatient clinics are supervised by attending faculty members on-site. Resident physician clinics are held in designated areas (or the same practice area as the faculty practice) and are supported in the areas of nursing, laboratory and other services in the same manner as the faculty practice settings.

Inpatient Settings at Night and on Weekends: Faculty members are available at DHMC 24 hours per day (or generally present in-house but available by telephone at all times). A faculty member will customarily see any complex or seriously ill patient promptly after admission. Immediate specialty consultations by attending faculty are available on-call at all times to resident physician staff in the same manner that is available to any active member of the medical staff. Faculty review all patients admitted by resident physicians. In the case of critically ill patients, an attending staff member usually initiates a treatment plan and/or consultants in the Emergency Room prior to transfer to the critical care units.

Emergency Room: Full-time emergency room faculty supervise resident physicians 24 hours per day. The faculty members are responsible for demonstrating and instructing resident physicians in proper emergency patient management. They supervise the clinical activity of the resident physician and assume the responsibility for evaluating the resident physician's clinical competence and delegating increasing patient care responsibilities as appropriate.

Evaluations

Assessment of Learning

DHMC recognizes learning on a continuum from novice to advanced beginner to competent at a level expected of a new practitioner. Each MHMH training program provides assessment of trainee learning in consideration of this continuum, aligned with basic RRC requirements as to the scope and number of both formative and summative evaluations.

Evaluation of Residents/Fellows

Written assessments of learning focus on a trainee's ability to perform up to defined expectations. These expectations are outlined in a program curriculum. Behavioral expectations are outlined in the DHMC *Code of Professional Conduct* and include the recording of procedures in case logs if required by the ACGME Residency Review Committee (RRC), and the timely and accurate reporting of duty hours. At scheduled intervals during the training year, written formative evaluations are provided to the trainee. At the conclusion of a training year, and at the end of the training program, written summative evaluations are provided to the trainee.

Quality Assurance for Residents/Fellows

All residency programs participate in the medical center-wide quality assurance system. Performance evaluations of residents are coordinated and administered by Residency Program Directors (staff physicians within a particular specialty). Performance evaluations are reflective of both academic knowledge and patient care/clinical skills. These evaluations are considered to be confidential and privileged (by New Hampshire laws RSA 151:13a, RSA 329:29a).

Quality Assurance Algorithm

1. Observation
   - A. Recognize problem
   - B. Develop plan
   - C. Method of assessment
   - D. Verbal notice to resident
   - E. Written notice in program file, noting verbal interaction only

2. Concern
   - A. Culpable or recurring adverse behavior or failure to respond to observed concerns
   - B. Written notification
   - C. Fair hearing policy
   - D. Remedial plan including problems, remediation, time frame, method to assess, and warning about possible need to report to the NH Board of Medicine.
   - E. Notice to GME and resident's file

3. Probation
   - A. Failure to meet remedial plan

B. Analysis of need for suspension
C. Written evaluation considering dismissal, non-renewal
D. Formal notice to GME and resident's file
E. GME report as needed to NH Board of Medicine

Evaluation of Faculty
Each MHMH residency program monitors educational effectiveness of faculty and attending physicians. At prescribed intervals, programs circulate amongst residents formal written evaluation forms to solicit feedback about individual faculty. These evaluations are confidential.

Program Evaluation
At prescribed intervals, programs circulate amongst residents formal written evaluation forms to solicit feedback about the program including curriculum, working environment, scholarly milieu, evaluation systems, and other features. These evaluations are confidential. Each MHMH residency program uses these resident assessments in their evaluation of the educational effectiveness of the residency program.

These program-based self-evaluations are in addition to the institutional internal review process to ensure continuous quality improvement.

Institutional Resident Duty Hours and Supervision Policy

DHMC is committed to the provision of a high-quality resident-training environment, balancing time for educational experiences with patient care responsibilities. We supervise and promote resident physicians' health and well-being while they learn to deliver safe, effective patient care. We have instituted and we support limits on resident work hours, while assuming responsibility for evaluating (and addressing) the impact of compliance with the ACGME Duty Hours requirements on our system of delivery of care and our resident physicians' educational experience.

Resident Duty Hours and the Working Environment
Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education have priority in the allotment of residents' time and energies. Duty hour assignments shall recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

1. Supervision of Residents
   A. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents training at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.

   B. Faculty schedules must be structured to provide residents with continuous supervision and consultation.

   C. Faculty and residents must be educated to recognize the signs of fatigue and apply policies to prevent and counteract the potential negative effects.

2. Duty Hours

A. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

B. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

C. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

D. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour-time period provided between all daily duty periods and after in-house call.

DHMC will not accept for review nor endorse any applications from individual GME training programs seeking exceptions to ACGME duty hour rules and regulations.

3. Call

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

A. In-house call must occur no more frequently than every third night, averaged over a four-week period.

B. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined in Specialty and Subspecialty Program Requirements.

C. No new patients, as defined in Specialty and Subspecialty Program Requirements, may be accepted after 24 hours of continuous duty.

D. At-home call (pager call) is defined as call taken from outside the assigned institution.

i. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.

ii. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

iii. The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

4. Moonlighting
   A. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

   B. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the Institutional Requirements III. D.1.k.

   C. Moonlighting that occurs within the residency program and/or the sponsoring institution or the non-hospital sponsor's primary clinical site(s), i.e., internal moonlighting, must be counted toward the 80-hour weekly limit on duty hours.

5. Program-Level Policy
   A. Each DHMC training program, regardless of ACGME-accreditation status, must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours.

   B. Each program must distribute these written policies to residents and faculty.

6. Education & Orientation
   A. Institutional and program leadership must project a clear message to all DHMC faculty and residents regarding the critical importance of adhering to the Institutional and Program Requirements for resident duty hours. The importance of honesty in reporting must be emphasized at every opportunity.

   B. The GME staff will incorporate an educational module into the general GME orientation emphasizing the institutional expectations of compliance with duty hours limitations as well as duty hours reporting compliance, and will include didactic material about the effects of sleeplessness and fatigue on physical health, cognitive development, and mental well-being.

   C. A review of the rationale for duty hours limitations, expectations regarding reporting compliance, and the importance of honesty in reporting must be provided by a figure of authority (Chair, Section Head or Program Director) to residents in every training program at the beginning of each academic year.

7. Reporting Procedures
   A. DHMC adopts a standard system for use by all residents to document duty hours. Currently this standard system is a part of the E-Value resident management system. GME Office staff assists with the adaptation of E-Value software for specific program use, as well as the training of program staff in the use of E-value, as needed. To ensure accuracy and timeliness of the data:

   B. Each resident is responsible for direct entry of their own duty hour information into the E-Value system.

C. The E-Value system will send an automated e-mail announcement on a weekly basis to all residents who have not completed their prior week's duty hour calendar.

D. A global set of duty hour labels are available to all programs to ensure reported data is consistent across programs.

E. The standard definition of "reporting compliance" is that within seven days of a month's end, each resident completes 100% of that month's calendar.

F. The GME Office utilizes a standard reporting form across all programs to track data relating to both reporting compliance and duty hour violations. All required data is derived from the E-Value system and may be acquired by GME staff independent of the training program.

G. In order to increase transparency, as well as foster improved compliance, the standard GME-generated data set will be made widely available to all residents, faculty, and administrative members of the DHMC community on a monthly basis.

8. Reporting Non-Compliance & Administrative Action

A. A standard threshold for "administrative action" in response to reporting non-compliance is adopted across all DHMC programs with the following thresholds and administrative actions:

B. For duty hours calendars not completed within seven days of month's end an email, notification of non-compliance will be automatically sent to the resident, the Residency Coordinator and the Program Director.

C. Receipt of three notifications of reporting non-compliance in any given academic year will generate a Letter of Concern from the Director of GME to be placed in the resident's QA file citing a pattern of reporting non-compliance that reflects negatively on the resident physician's professionalism.

D. Continued reporting non-compliance following receipt of a Letter of Concern will trigger a review by the GME Duty Hours Subcommittee and may result in disciplinary action up to and including dismissal.

E. The GME Confidential system will be available for confidential reporting and/or guidance regarding issues related to duty hours. The system will forward all reports to the designated resident representative on the Duty Hours Committee.

F. A specific question addressing the issue of faculty encouraging residents to misrepresent their duty hours, work beyond their hours, or otherwise violate duty hours requirements should be incorporated into the vehicle used by residents to evaluate faculty in every DHMC program. If for any reason a resident is uncomfortable utilizing this option then the GME Confidential system should be used as a confidential avenue for reporting this issue.

9. Duty Hours Subcommittee

A. The GMEAC will have a standing Duty Hours Subcommittee. This subcommittee is composed of the GME Office leadership team, one program director, and three resident representatives. The Duty Hours Subcommittee is charged to:

i. Periodically review data sets generated from the E-Value system;

ii. Periodically review/update the DHMC Duty Hours Policy;

iii. Periodically review all confidential suggestions/concerns submitted through the GME Confidential system;

iv. Periodically report to the GMEAC;

v. Review cases and make decisions regarding disciplinary action for egregious reporting non-compliance:

vi. Arbitrate significant resident/program issues related to duty hours.

GMEAC review and approval history: March 23, 2003. Approved Revision, January 23, 2006.

V. House Staff Assistance

GME Resident Confidential Hotline

Nancy Morley from Education/Employee Relations is available to individual residents to address concerns in a confidential protected manner. She will listen to concerns, brainstorm potential solutions and/or make suggestions about next steps. Nancy will answer questions about DHMC policies and help find appropriate resources, when needed. Nancy's hours are 8-5pm, Monday through Friday. Call or page her at beeper 8086 or phone 603-653-0485. She will return calls within 24 hrs unless she has taken time off from work. There is always a back-up on-call staff person in Education/Employee Relations for emergent situations.

GME House Staff Assistance

GME will act as advocate for house staff members and will act to promote and maintain house staff physician well-being and, when necessary, rehabilitation. Confidentiality of house staff will be paramount.

GME will provide procedures to assist house staff; a training and education program for house staff; and will provide them with an awareness of problems that may lead to impairment. GME will establish methods for assessment and treatment of house staff members who are impaired.

House staff may call the Employee Assistance Program (EAP) at 603-650-5819 and ask for consultation, counseling and referrals. House staff members may call GME and ask for Jake Kelleher, Administrative Director, or H. Worth Parker, MD, Director of GME, and be given the names of providers with specific expertise. House staff may also consult the Provider Expertise List for assistance.

At GME Orientation, and in the *Red Book* provided annually, all house staff are given information about resources that include counseling, psychological support services and related assistance, as part of the GME House Staff Assistance and Education Program.

DHMC Employee Assistance Program

- A ***free*** and ***confidential*** counseling service.
- A ***benefit*** provided by the Hospital and Clinic for all employees and their family members.
- Up to six visits per year with a professional counselor.
- Assistance with a variety of difficulties (e.g., family relationships, emotional or physical well-being, and/or job performance issues).
- A referral source when extended counseling, support, or medication is needed; or when there are medical, legal or financial problems.

The office is open from 8am to 5pm, Monday through Friday. For more information, please visit the Employee Assistance Program Website or call (603) 650-5819. You may leave a message 24 hours a day and your call will be returned as soon as possible.

Please note: Employees/family members may also contact the program directly; a supervisor may suggest using the EAP; a friend, family member, coworker, or health care provider may also refer employees/family members to the EAP.

VI. Graduate Medical Education Policies

Leave of Absence Policy

December 6, 2004 – Approved and accepted by the GME Advisory Committee

It is the policy of DHMC to make leaves of absence (LOA) available to its House Staff employees (interns, resident or fellows) to meet individual needs in accordance with the intent of the following policy. Specific information on appropriate process and benefit continuation is available at the Graduate Medical Education (GME) office.

Satisfactory resolution of issues affecting the on-call schedule is the responsibility of the resident requesting LOA and the Program Director. Consideration should be given to the needs of that House Staff member, the welfare of others training in the program, and the needs of the program as a whole.

Each specialty board residency review committee (RRC) and/or intramural residency program has its own unique requirements related to board eligibility or program completion. House Staff members may be required to make up absent time should there be a limit on missed time from training as specified by any of these bodies. In general, if the House Staff member received appropriate pay, ie: unused vacation time, during this leave, the make up time will be served with pay. If the leave was not paid during this leave, the pay scale will be identical to the pay scale in force during the leave when the House Staff member returns to duties.

DISABILITY LEAVE Medical Leave of Absence

A leave of absence (LOA) for a resident's own medically verified disability will be granted for the length of the disability to a maximum period of 90 days. All House Staff members, regardless of benefit status or hire date, are eligible for a disability leave of absence.

For the purpose of this policy, disability includes any injury or illness including those arising from pregnancy, childbirth, and related medical conditions that temporarily impede a resident from being able to perform the essential functions of their position. A female House Staff member affected by pregnancy, childbirth or related medical conditions will be treated in the same manner as any resident affected by any other temporary disability. Any House Staff member absent from work, or expected to be absent from work for more than two consecutive calendar weeks due to disability should be placed on disability leave. The leave date begins on the initial date of the inability to work because of the disability.

Mothers of newborn babies may request up to an additional six weeks of personal leave beyond their disability leave for delivery. **Unless this further six weeks is based on medical necessity or requested as vacation time, it will be unpaid.** The combination of the disability and personal leave should not exceed 12 weeks (90 days).

House Staff members on disability leave will be reinstated to a position in accordance with the Family and Medical Leave Act of 1993, if applicable. For situations that extend beyond FMLA protection, the reinstatement policy will be as stated in the GME Red Book except in workers' compensation situations when an employee has a potential right to job reinstatement for eighteen (18) months from date of injury. Also, see Specialty Board Requirements in Leave Policy. Depending on the nature of the medical leave, a Program Director may request a Fitness for Duty evaluation through Occupational Medicine prior to the resident's return to work.

Disability leave may be granted with full pay and continued benefits for 90 days. Disabilities extending beyond 90 days will be covered according to Long Term Disability (LTD) policy. This would include disabilities involving pregnancy, pre and post partum.

Medical Benefits While Out on Leave of Absence

Medical benefits may be continued for House Staff on approved leaves of absence for up to a total of 12 months beginning from the first day of the leave.

Personal Leave

A leave of absence (LOA) for personal reasons may be granted to House Staff with at least one year of continuous service at DHMC for a period up to, but not exceeding, 90 days. This leave will be unpaid. A personal leave may be used by male house staff in the event of a birth of child, or for the adoption of a child. The leave will commence at the birth or placement of the child.

Personal leave must be approved by the Program Director, Department Chairperson and the Director of GME. It is suggested that personal leaves not qualifying under the Family and Medical Leave Act (FMLA) be submitted at least 60 days in advance. Application for personal leave is accomplished by completing and submitting the GME LOA Request Form. See Specialty Board Requirements in previous section.

Family And Medical Leave Act (FMLA)

In January 1993 the Family and Medical Leave Act (FMLA) was passed by Congress and became law in August 1993. This Act entitles employees who have worked for at least one year and completed a minimum of 1250 hours in that year up to 12 work weeks away from their employment due to serious health conditions of their own, or of certain family members. The Act states this is an unpaid leave that guarantees job reinstatement and continuation of benefits up to12 weeks in a rolling year (a rolling year begins when the event occurs and rolls to one year to the day later). DHMC House Staff are paid for the disability leave portion of their FMLA by DHMC policy.

Qualifying events covered by FMLA are:

(1) The birth of a child of the House Staff member, and to care for such child
(2) The placement of a child with the House Staff member for adoption or foster care
(3) To care for a spouse, child or parent of the House Staff member if such spouse, child or parent has a serious health condition (see definition)
(4) A serious health condition that makes the House Staff member unable to perform the functions of their job

A serious health condition is defined as an illness, injury, impairment or physical or mental condition that involves inpatient care in a hospital, hospice or residential medical care facility, or continuing treatment by a health care provider for more than three days.

As stated, FMLA is an unpaid leave except in disability situations of the House Staff member. Benefits will be continued during the FMLA. Should the House Staff member fail to return from leave, the employer may recover the premium for the dental coverage incurred during the leave time.

Family leave may be taken on an intermittent or reduced hourly schedule. This arrangement requires approval from the Program Director and the Director of GME.

Two House Staff members who wish to take leave to care for their newborn, or newly placed child, are limited to a 12 week aggregate. However, a leave requested for a serious medical condition of a qualifying member (child or spouse) entitles both members to 12 weeks each.

Bereavement Leave

In the event of a death in the immediate family, the Department Director or Practice Manager may approve up to five (5) days bereavement leave with pay (equals 40 hours for employees in the F40 employment benefit classification, and is pro-rated for others). Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinic North acknowledge that some relationships are generally closer than others. For those relationships, the Department Director or Practice Manager may give the maximum of five (5) days of bereavement leave with pay. For these purposes, immediate family includes: spouse, partner, parents, grandparents, grandchildren, mother/father-in-law, brother, sister, step-parents, step-brother, step-sister, child, step-child, brother-in-law and sister-in-law. The leave may be used over an extended period of time to accommodate the reasonable needs of the employee.

The intent of the policy is to provide time to recognize the emotional impact of the death of a member of the immediate family. The Hospital and Clinic accepts that there may be other relationships which have equal meaning to an employee but cannot provide bereavement paid time off for all such extended relationships. If it does not impact departmental functions, Department Directors/Practice Managers will try to approve unpaid time off, or Earned Time requests for such non-covered situations.

Moonlighting Policy

Reviewed and Approved by the GMEAC January 23, 2006

For purposes of this document the term *resident* will be used for residents and fellows. The term moonlighting means to work for pay outside the requirements and stipend of the Dartmouth-Hitchcock Medical Center training program and applies to **DHMC residents and fellows only**.

General

1. Dartmouth-Hitchcock Medical Center neither encourages nor discourages moonlighting. House staff are not required to Moonlight.

2. The resident must have a permanent license to practice medicine in each state where he/she moonlights. A permanent license is different from a training license. It is the sole responsibility of the resident to apply for and obtain a permanent license.

3. The resident must obtain written permission to moonlight from Graduate Medical Education and his/her Program Director

4. Graduate Medical Education and the resident's Program Director will monitor and ensure moonlighting or *locum tenens* work does not interfere with the ability of the resident to meet the goals, objectives, assigned duties and responsibilities of the Program and ensure resident reporting of and compliance with duty hour requirements. All moonlighting work hours done within DHMC must be reported by the resident as regular duty hours. These duty hours will be calculated and become part of the residents' total hours worked and are subject to all ACGME duty hour regulations.

5. The resident's Program Director must sign the Moonlighting Request Form identifying moonlighting assignments and may restrict moonlighting based upon training program considerations.

6. Residents pursuing *locum tenens* or who moonlight outside of DHMC are not covered by DHMC liability or malpractice insurance.

GME Concern Policy

As revised and adopted by the GMEAC, December, 2000

A concern is defined as an issue perceived by a resident or program director as needing resolution. Generally, such a matter will not significantly threaten a resident's intended career development nor have the potential of leading to a recommendation of dismissal or non-renewal.

Process for Addressing House Staff Concerns

House staff concerns may be brought to the Chief Resident, Program Director, Department Chair, the House Staff Association, or to the Office of Graduate Medical Education. The process of mediation is available for house staff to address concerns or differences and eliminate or resolve a concern in a confidential and protected manner without fear of reprisal.

Discussion

Step I: Any concern may be discussed first with the Chief Resident, Residency Program Director, and/or the Department Chair. Discussions may include a member of the House Staff Association.

Step II: If not resolved, the concern may be brought to the attention of the Director or Administrative Director of Graduate Medical Education. The house staff member may also come directly to the Office of Graduate Medical Education and discuss the concern confidentially. The Office of Graduate Medical Education may act as mediator and intercede for the house staff member, so as to try to reconcile differences and resolve the concern in a confidential manner. The resolution of the Office of Graduate Medical Education using appropriate interaction with the resident, Program Director, and any others deemed integral to the decision, will be final.

GME Fair Hearing Policy

As revised and adopted by GMEAC, December, 2003

I. Purpose

The purpose of this policy is to delineate Fair Hearing procedures which assure due process to Residents who have concerns or are recommended for non-renewal or dismissal from a program due to academic deficiency, non-academic deficiency or behavior incompatible with the role of the physician, or for other reasons that, if not resolved, could significantly threaten a Resident's intended career development.

II. Procedures

A. Academic Deficiency

Definition: Academic deficiency shall include, but not be limited to: a) insufficient fund of medical knowledge, (b) inability to use knowledge effectively, and/or (c) behavior detrimental to the educational process or the care of patients.

Length and Goals of Remediation: A Resident whose academic performance does not meet departmental standards may be entitled to a defined period of remedial training in order to allow the Resident to improve academically and remain in the program.

B. Non-academic Deficiency

Definition: Medical and surgical disciplines require unique abilities and talents which are unrelated to intellect, motivation or other academic qualities common to the physician. When a Resident's non-academic abilities and talents are judged insufficient by the Program Director, notification should be offered at an early stage, when a change in career direction will be least disruptive to the Resident.

Length and Goal of Remediation: A Resident whose non-academic performance does not meet department standards may be offered a defined period of remedial training in order to allow the Resident to improve and remain in the program. If correction is not deemed feasible by the Program Director, the Resident's exploration of career alternatives and Program Director's assistance in finding a position more in keeping with the Resident's abilities and talents will take place.

C. Behavior Incompatible with the Role of the Physician

Definition: Some behavior may be judged by the Program Director to be illegal, immoral, unethical or so objectionable as to be incompatible with the role of the physician. When such behavior on the part of a Resident has been alleged and not refuted to the Program Director's satisfaction, the Program Director, after discussion with the Director of GME, may recommend the Resident's dismissal without an intervening probationary period.

Length and Goal of Remediation: There is no right to remediation under these circumstances.

D. Procedure for Notification of Non-renewal, Dismissal or Other Concerns

1. The Resident shall be informed in writing of the documented deficiencies or allegations and of the recommendation for non-renewal, dismissal or remedial training in a private meeting with the Program Director or a duly appointed representative. At this meeting or as soon thereafter as possible, the Resident shall be provided with a copy of this policy.
2. The Program Director shall submit written notification of the deficiencies, allegations and recommendation for non-renewal or dismissal to the Resident, the Director of Graduate Medical

Education, the Chief of Staff of the Veterans Affairs Medical Center (White River Junction, Vermont) and the GMEAC where appropriate.

3. The Resident shall have five days, or within a mutually agreed upon time, from the date of this written notification to either (a) agree to the remedial plan (b) submit a resignation effective at a mutually acceptable date within the context of these guidelines, or (c) request a review of the case from the Director of Graduate Medical Education.
4. If the Resident does not reach resolution after meeting with the Director of GME and attempted mediation, the Resident may request a review in a written request for the Fair Hearing Process, as described below, to be followed.

III. Fair Hearing Process

At any time during this process, the Resident may resign. Once a written resignation has been delivered to the Program Director, however, the Resident shall be deemed to have waived all rights to a hearing or to a continuance of his/her appointment.

A. Hearing Procedure

1. Upon notification by the Resident that a review is requested, the Director of Graduate Medical Education or his designee shall form a committee consisting of the Director of Graduate Medical Education or his designee, a Hospital administrator, a house officer and two program directors or one program director and one physician faculty member selected by the Director of Graduate Medical Education or his designee (hereafter called the Committee.) The Director shall not select any person having a direct working relationship with the Resident. The Director of Graduate Medical Education or his designee shall chair the Committee.
2. The Committee shall schedule a hearing to occur within 14 days, or within a reasonable period of time based upon availability of the Resident, Program Director and Committee, but not less than seven days from the date of the Resident's request for review. In the interim, the GME Office shall obtain all relevant evaluation and academic records.
3. All evidence available to the Committee shall be provided to the Resident and Program Director at least three *working* days prior to the hearing. The specification of reasons for non-renewal or dismissal or other factors in the original written notice shall not prevent the Committee from relying on other reasons which are presented at the hearing; provided that the Committee may, at the request of the Resident and without special notice, recess the hearing and reconvene later in order to allow the Resident adequate opportunity to address reasons not included in the notice. The Committee may also, at its sole discretion and without special notice, recess the hearing and reconvene later in order to study new evidence presented by the Resident at the hearing.
4. The Resident shall be present and prepared to proceed at the scheduled hearing or shall be deemed to have waived all rights to a hearing and to have accepted any adverse recommendation or decision made by the Committee. Another hearing may be scheduled at the Committee's sole discretion if the Resident presents good cause for failing to appear or proceed. Hearings scheduled under these Guidelines shall be postponed only for good cause and at the sole discretion of the Committee.
5. The Resident and the Program Director may invite up to five witnesses each to present before the Committee. The Resident and Program Director may also ask others not invited to speak to submit written statements which will be collected for the GME Office at least five days prior to the hearing date.
6. The GME Director may appoint a separate hearing officer or designate a member of the Committee to preside over the hearing, to determine the order of procedure, to assure that all

participants have a reasonable opportunity to present relevant oral and documentary evidence, to maintain decorum and to make any necessary procedural rulings.

7. The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or the presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered.
8. The Resident shall be entitled to submit, either prior to or during the hearing, memoranda concerning any issue of procedure or fact and such memoranda shall become part of the hearing record.
9. The order of presentation shall be determined by the Chair of the Committee. The Program Director shall be responsible for presenting appropriate evidence in support of the decision being questioned by the Resident. The Resident shall be responsible for presenting evidence which contradicts the Program Director's evidence or indicates that the Program Director's decision was arbitrary, unreasonable or capricious.
10. The Resident, the Program Director and the Committee may be entitled to consult with legal counsel in preparation for the hearing or with regard to other related matters.
11. Neither the Resident nor the Program Director shall be represented at the hearing by an attorney.
12. The Resident or Program Director may utilize a DHMC physician or staff member as an advisor during the Fair Hearing Process. This advisor may be present throughout the hearing.
13. The Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.
14. The hearing may not be tape-recorded.

B. Post-Hearing Procedure

1. The Committee shall conduct its deliberations in closed sessions. Only Committee members will be permitted to observe or participate in the deliberations.
2. Within 14 days, or a reasonable period of time after the conclusion of the hearing, the Committee shall make its final decision and shall deliver written notice thereof to the Program Director and the Resident. The notice shall indicate the reasons relied upon by the Committee in reaching its decision.
3. In the event the Committee should not concur with the Program Director's recommendation for non-renewal or dismissal or other issues regarding the Resident, the Program Director may be asked to accept the Resident in the departmental program for an additional period of specified duration during which remedial efforts may be continued on the Resident's behalf. The Resident's appointment shall be continued under such conditions as shall be defined in writing by the Program Director to the Resident and to the Director of Graduate Medical Education.
4. There shall be no appeal from the decision of the Committee.

Reduction in Program, Loss of Accreditation, or Closing Program Policy

Approved by the GMEAC, September 18, 1997

Commitment will be made by GME to ensure the DHMC Residency Training Program has continued support through the academic year and/or through completion of training by the current number of house staff before it is closed. The GME Resident Agreement will indicate clearly the agreement is for one training year at a time only, and renewal is dependent upon many factors including requirements set by the Accreditation Council for Graduate Medical Education.

GME will assist with new program information and transfers and communication with prospective program directors as appropriate.

Time Lost From Residency Training Years

Time lost from residency training must be made up according to the specifications of the Accreditation Council for Graduate Medical Education, Residency Review Committee for that particular specialty, and at the discretion of the Program Director.

Remuneration for time off, other than the specified three weeks paid vacation per year, and the particular benefits of health coverage, will be at the discretion of the Program Director and Director of Graduate Medical Education. House staff personal time and conference time is allowed at discretion of Program Director.

Professional Deportment and Consideration of Others

House staff and other health team members should not expect to be mistreated or abused, nor be participants in the behaviors listed below. Any concern about the following may be discussed first with the residency program director, chief resident, and/or the department chairman. If not resolved, the concern may be brought to the attention of the Director or Assistant Director of Graduate Medical Education. The house staff member may also come directly to the Office of Graduate Medical Education and discuss the concern confidentially.

1. **Verbal abuse**
    - Being yelled at
    - Experiencing inappropriately nasty, rude or hostile comments
    - Being belittled or humiliated
    - Being cursed or sworn at
2. **Psychological-Institutional-Academic-Educational Abuse**
    - Being assigned tasks as punishment rather than for educational purposes, such as running personal errands or arranging meals for others
    - Academic neglect or lack of communication
    - Inappropriate scut work (no learning value)
    - Threatening an unjustifiably bad evaluation
    - Having someone else take credit for your work
    - Unwarranted removal of normal privileges
    - Unfair or malicious competition
    - Having others put you at an unfair disadvantage by cheating
    - Hostility from others after an academic or research achievement

- Having others try to turn a supervisor against you
- Making negative remarks to you about training as a physician
- Excessive workload
- Excessive sleep deprivation

3. **Physical abuse**
   - Threatening you with physical harm
   - Subjecting you to physical harm or unwanted touching
   - Placing you at unnecessary medical risk, such as having you do procedures for which you have not been trained or feel ready to perform, on patients whose illnesses could pose a risk to you
4. **Sexual Harassment**
   - Sexual advances or requests for dates or sex
   - Unwanted physical contact
   - Speculation about one's sexual behavior or orientation
   - Sexual slurs or names
   - Discomfiting humor
   - Malicious rumors
   - Implication that opportunities are being offered or withheld based upon physical attributes, behavior or participation
5. **Discrimination based upon gender, culture or race**
   - Stereotyping based upon gender, culture, race or arbitrary personal characteristics
   - Slurs or demeaning terminology
   - Discomfiting humor or humor based upon stereotypes
   - The implication of superiority or inferiority based upon gender, culture or race
   - Stated or implied slurs about a group, or an individual as a member of a group, based upon gender, culture, race or other arbitrary characteristics
   - Implication that opportunities are being offered or withheld based upon gender, culture, race or other arbitrary characteristics
6. **Ethical or professional misconduct**
   - Cover-up of mistreatment of patients or others
   - Alcohol or drug abuse
   - Falsifying information
   - Cheating in research
   - Cover-up of unethical behavior

11-5-02gme

VII. DHMC By Laws

Excerpted from the Prof Staff Bylaws/Sections 5, 6 & 10/R&R 09-22-05 v2

Resident Staff

A. **Eligibility**
The Resident Staff shall consist of Physicians who:

1. Have been admitted to a Hospital professional graduate training program as residents or fellows; and
2. Have been duly appointed to the appropriate Section within the Clinical Department to which they are assigned.

B. **Prerogatives**
The prerogatives of a Resident Staff member shall be to:

1. Attend with voting privileges any meetings of any Professional Staff committee to which he has been assigned or elected; and
2. Practice within the scope of practice defined by the Graduate Medical Education Program.

C. **Responsibilities**
Responsibilities of membership on the Resident Staff include but are not limited to:

1. Adhere to the specific policies and procedures in the Graduate Medical Education Program "Red Book", Policies and Procedures for House Staff.

The Resident Staff do not have independent privileges to admit or treat patients in the Hospital.

Appointment of Resident Staff

A. Notwithstanding any provision of these Bylaws to the contrary, appointments to the Resident Staff shall be deemed to have been made without the need for application as provided in these Bylaws, based on the educational program agreement between the GME Office and the Hospital, for periods not to exceed one year. Termination from such educational program, for whatever reason, shall automatically result in the termination from the Resident Staff without right to a hearing or appellate review. Reappointment shall occur on an annual basis throughout the duration of the residency and shall be based on evidence of satisfactory progress in scholarship and professional growth and the availability of training positions.

B. Recommendations for appointments to the Resident Staff shall be initiated by the respective Department Chair and are to be based on review of the Applicant's academic records and references after verification of the qualifications of such Applicants. Such recommendations for appointment shall be made to the GME Office who, in turn, will review the applications and supporting documents and endorse those which appear to be in order. Those which are in order shall be referred to the Boards of Trustees for final appointment.

C. Members of the Resident Staff cannot be transferred to any other category of the Professional Staff. Such individuals who desire membership in another Professional Staff category during or after completion of the educational program must apply for such membership in the same manner as any other Member. The foregoing shall not be construed to preclude an individual who is otherwise eligible

from applying for a different category of Professional Staff membership in accordance with these Bylaws.

Supervision of Students

A. **Medical Students**
Designated medical students may, under the supervision of a Member, perform invasive techniques or administer medication.

B. **Housestaff**
It is the responsibility of the Attending Physicians to supervise the care provided by the Housestaff. Each Attending Physician participating in the supervision of Housestaff shall possess clinical privileges appropriate to the activities of the Housestaff under his direction.

The physician responsible for the supervision of interns, residents, and fellows will document their services as outlined by the Teaching Physicians guidelines by the Center for Medicare and Medicaid Services. It is the responsibility of the teaching physician to stay current with these requirements.

VIII. General Policies

Drug and Alcohol Policy

Mary Hitchcock Memorial Hospital is responsible for providing a safe environment for patients, visitors, house staff and employees. It is the policy of Mary Hitchcock to establish the Hospital as a drug-free workplace and to provide a drug-free awareness program. It is also a condition of house staff employment under federal law to abide by the terms of this policy.

To meet the objective of assuring a drug-free workplace, the Hospital requires that:

- The manufacture, distribution, use, sale, purchase, transfer or possession of a controlled substance during working hours and/or on Hospital property is prohibited, unless performed by those legally authorized to do so as a part of necessary patient-related care.
- House staff are not permitted to work while under the influence of alcohol or controlled substances except as otherwise qualified herein.
- House staff who are using drugs as a medical therapy must use them only in accordance with a valid prescription by a licensed physician.
- Use of prescribed or over-the-counter drugs that may impair ability to function must be disclosed to the attending supervisor.
- House staff will be subject to disciplinary action, up to and including dismissal, for bringing unauthorized drugs or alcoholic beverages to work, being under the influence of such substances while working, using them while working, or dispensing, distributing, selling or manufacturing them in unauthorized or illegal manner on Hospital premises, work sites or property.
- House staff experiencing drug- or alcohol-related problems are strongly encouraged to seek help through the hospital's Employee Assistance Program (EAP), 603-650-5819. EAP counseling is confidential and is not part of the house staff's personnel file or medical record and will not have an impact on an individual's performance appraisal. Job performance alone, not the fact that an employee is receiving counseling, will be the basis for all performance appraisals.
- House staff diagnosed as chemically dependent may be granted a medical leave of absence to undertake rehabilitation treatment. House staff returning from leave will be requested to complete a follow-up treatment plan with the EAP counselor before returning to work.
- A hospital security representative may search house staff and their personal property, as well as Hospital facilities and property, if there is reasonable cause to believe that any part of this policy is being, or has been, violated.
- House staff may be requested to have a medical assessment, including blood and urine testing, to determine the presence or absence of drugs or alcohol in their systems where there is reasonable cause to believe that the house staff member is or has been working while under the influence of drugs or alcohol. Mary Hitchcock will take reasonable steps to confirm test results and maintain confidentiality. House staff who refuse to submit to such testing will be subject to discipline, up to and including immediate discharge.
- Federal law requires that house staff paid through a federal grant notify their program director of any criminal drug statute conviction occurring in the workplace no later than five days following the conviction. If an employee is paid through a federal grant and notifies his/her program director of a conviction, Mary Hitchcock is required to notify the federal agency within ten days after receiving notice from the employee of such a conviction. House staff must also indicate on their training license

application for the Board of Registration in Medicine for the State of New Hampshire whether they were or are now dependent on alcohol or drugs. The Board reserves the right to perform further background checks after issuance of the house staff training license.

Required Tests

Reasonable Suspicion Drug or Alcohol Tests

An employee or house staff member must submit to a work impairment evaluation, including drug or alcohol testing, when a manager or supervisor believes that the employee or house staff member may have or has violated the drug or alcohol prohibitions contained in this policy. Reasonable suspicion determination must be based on specific, current observations that may be verbalized, including, but not limited to, the employee's appearance, behavior, speech, or body odors. In addition, these observations may include indications of the chronic and withdrawal effects of drugs or alcohol. A reasonable suspicion determination may be based on a single instance of misconduct including the failure to perform or the improper performance of an employee's job duties or any conduct which involved a potential risk of harm to our employees, patients, visitors, or other individuals working at the hospital or on its property.

Any supervisor or manager who has reasonable suspicion to believe that an employee or house staff member violated this policy, may immediately remove the employee from work and request such employee or house staff member be evaluated by the Occupational Medicine Department.

Self-Identification of Substance Abuse Problem

If an employee or house staff member voluntarily self-identifies as having a drug or alcohol problem and voluntarily requests assistance for such a problem prior to being selected for a drug or alcohol test required by this policy, the Hospital will refer such employee or house staff member to the Hospital's Department of Occupational Medicine for an evaluation and the Employee Assistance Program for referral to an appropriate counseling, treatment or rehabilitation program, if recommended. Upon such employee's or house staff member's return to duty, he or she may be required to submit to a drug or alcohol test and, if tested, must receive a negative result. Such employee or house staff member also may be required to submit to follow-up testing in accordance with the applicable Agreement of Rehabilitation and Conditions for Continued Employment.

Consequences for Refusal to Submit to Tests and Policy Violations

The Hospital has determined the following consequences for all employees or house staff members found to have violated this policy:

Refusal to Submit

Any employee or house staff member who engages in the following conduct, which constitutes a refusal to submit, will be subject to disciplinary action up to and including possible termination: (1) failure to complete the testing forms; (2) failure to provide a specimen, or an adequate amount of specimen; (3) engaging in conduct that clearly obstructs the testing process, including the adulteration of substitution of a urine specimen or attempting to substitute or adulterate a specimen; (4) failure to notify the Hospital that he or she was in an accident/incident as described by this policy or is not ready for testing after an accident/incident (except as necessary to obtain assistance or medical care); (5) failure to report directly to the collection site after notification; or (6) delaying the collection, testing or verification process.

Non-Discrimination, Equal Employment Opportunity, and Affirmative Action

It is the policy of Mary Hitchcock Memorial Hospital to provide equal employment opportunities for all house staff, employees and applicants, in compliance with our Affirmative Action Plan, as follows:

- To recruit, train, hire, transfer, and promote in all job classifications without regard to race, color, religion, age, sex, national origin, physical or mental disability, veteran status, sexual orientation or marital status.
- To base decisions on employment in accordance with the principles of equal employment opportunity.
- To make promotion decisions in accordance with the principles of equal employment opportunity.
- To provide that all other personnel actions and terms and conditions of employment will be administered without regard to race, color, religion, age, sex, physical or mental disability, national origin, sexual orientation, or marital status.

The Equal Employment Opportunity Officer for Mary Hitchcock Memorial Hospital is William V. Geraghty, Vice President of Human Resources.

The Dartmouth-Hitchcock Privacy Group
Policy Statement on the Privacy & Confidentiality of Patient Information

XIII. *Statement of Purpose*

It is our intent to establish policies and procedures governing the privacy of our patients' personal health information and to provide guidelines for the security and appropriately controlled release of such information, consistent with applicable federal and state laws, including the federal privacy rule.

We support the patient's right to privacy (that is, the right to control access to his or her personal health information) and accept responsibility to keep secure and confidential the information collected about our patients during their encounters with us. We also understand that releasing parts or all of that information is appropriate under certain circumstances, such as providing for continuity of care, participating in approved research and educational activities, complying with laws, and assuring reimbursement for services provided, and that such releases provide benefit to the patient and/or to society.

SCOPE AND DEFINITION OF TERMS

This Policy Statement applies to all personnel of the Dartmouth-Hitchcock Clinic, the Mary Hitchcock Memorial Hospital, the Dartmouth Medical School, and other members of the Dartmouth-Hitchcock Privacy Group (together, "Dartmouth-Hitchcock"), as well as business associates, volunteers, and students participating in medical educational programs within these organizations.

This Policy Statement applies to all types of personal health information, regardless of form. Health information is information we receive or create relating to someone's past, present, or future physical or mental health or condition, or the provision of or payment for health care provided to someone. Personal health information (defined in the federal rule as "individually identifiable health information" or "protected health information") is any item containing health information about a patient that reasonably could directly or

indirectly identify the patient, whether in electronic, hard copy, oral, or any other format, original or copied, or any electronic data base, whether free-standing or networked, or any medical records, whether maintained by the medical records department or any other department, section, or provider. This Policy Statement covers personal health information regardless of storage medium or location. In addition to medical records, it covers operating schedules, registration forms, billing and claims information, financial documents, patient conference notes, provider's personal notes, photographs or videos, information in registries, room assignments, radiology films, cine film, computer-generated microfilm, electronic mail correspondence, etc. We expect technology to continue to change the media upon which patient information is stored, and we intend to extend our privacy policies and procedures to these as they come into use in our facilities.

Types of release covered by this Policy Statement ("uses" and "disclosures" as defined by the federal privacy rule) include, but are not limited to, written, verbal, telephonic, or electronic, transmitted intentionally or unintentionally, in public or in private, inside or outside the walls of our organizations. Also included is information released to regional health data networks, insurance companies, managed care providers, medical data banks and other data repositories, affiliated institutions, researchers, business associates, government agencies, news organizations, pharmaceutical and medical equipment suppliers, clergy, and family and friends of patients – in short, all releases of personal health information.

This document provides philosophy and direction for decision-making and procedure development throughout the Dartmouth-Hitchcock Privacy Group. Medical record departments will develop implementation policies to provide mechanisms for appropriate protection and releases of information. These implementation policies will define the circumstances under which an unauthorized access to or release of a patient's personal health information will constitute a breach of confidentiality. At a minimum, any disclosure of personal computer password(s) which risks unauthorized access to confidential patient information will be construed as a breach of confidentiality. If you have any questions about this Policy Statement or release of any patient-related information, contact the medical records department in your institution.

For the entire policy, please see http://policy.hitchcock.org/dspPolicyWindow.cfm?policy_id=189

Vendor Sponsored Meals and Gifts

PURPOSE and SCOPE: This policy establishes practice regarding:

- The provision of food/meals by the pharmaceutical, medical device industry or any other vendors to employees of Dartmouth-Hitchcock Clinic or Mary Hitchcock Memorial Hospital
- The acceptance of gifts, regardless of value, by any Dartmouth-Hitchcock Clinic or Mary Hitchcock Memorial Hospital employee from any pharmaceutical, medical device, or other vendor

POLICY

- The provision of food, in the form of "snacks" or full meals, and the acceptance thereof by any employee of Dartmouth-Hitchcock on any Dartmouth-Hitchcock campus is strictly prohibited.
- The acceptance of gifts or trinkets of any kind, regardless of value, is prohibited at all times.
- Employees are reminded that governmental agencies may be monitoring and publishing documented instances of gift giving (including meals) to physicians and/or others.

For full details, please go to the Clinical Policy Library on the DHMC Intranet
http://policy.hitchcock.org/dspPolicyWindow.cfm?policy_id=4021

Legal Counsel
If you are approached for any reason by a representative from a law firm, your representation is by the Dartmouth-Hitchcock Medical Center, Mary Hitchcock Memorial Hospital Risk Management office, and you should refer all calls to them at ext. 5-7864.

Sexual Harassment Policy

Dartmouth-Hitchcock is opposed to and will not tolerate sexual harassment in the workplace. Complaints of such harassment will be thoroughly investigated, and if the person is determined to have committed an offense, he/she may be subject to discipline up to and including dismissal.

Sexual harassment includes unwelcome sexual advances, or requests for sexual favors, or verbal or physical conduct of a sexual nature from supervisors, coworkers or in some cases non-employees when:

1. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment or status as a House Officer;
2. Submission to or rejection of such conduct by an individual is used as the basis for employment or academic decisions affecting him or her, or for the awarding or withholding of favorable employment or academic opportunities, evaluations or assistance, or
3. Other verbal or physical conduct related to sex when such conduct has the purpose or effect of substantially interfering with an individual's performance at work or in study by creating an intimidating, hostile or offensive environment in which to work or learn.

The procedure to be followed by an employee who believes himself/herself to have been a victim of sexual harassment is as follows:

Any employee who believes that he/she has been sexually harassed by a supervisor, agent of Dartmouth-Hitchcock, coworker or other person should either submit a written statement describing the incident(s) to his/her supervisor, or to the Divisional Director of Operations, or to the Human Resources Department or speak in person to one of the above-named individuals concerning the incident. If the employee chooses to speak to any of the people identified above, such persons may make written notes to aid in the investigation of the employee's claims.

In the event that any claim of sexual harassment is made by an employee of Dartmouth-Hitchcock to his/her supervisor, the supervisor shall promptly inform the Divisional Director of Operations and the Human Resources Department. Upon receipt of a claim alleging sexual harassment, Dartmouth-Hitchcock will use its best efforts to promptly and thoroughly investigate the charges made by the complaining employee. Except as required by the demands of the investigation and enforcement if the policy, the employee's complaint will be treated confidentially. Any person found, after a complete and thorough investigation, to have violated Dartmouth-Hitchcock's policy against sexual harassment, may be subject to discipline up to and including dismissal. The filing of a claim of sexual harassment will not jeopardize the employee's job or the terms or conditions thereof.

Jury Duty
The Hospital believes it is the civic responsibility of an employee or house staff member to fulfill his/her jury duty obligation, and will ensure that he/she does not lose normal pay during that duty. The Hospital will not

attempt to have a release from such service. It is expected that, with due consideration to time and travel factors, the employee or house staff member will return to work when a court recess temporarily releases him/her from jury duty.

Reimbursement: The house staff member will be fully compensated by the Hospital for time spent on jury duty. The employee or house staff member may accept any additional pay received from the state for jury duty.

Dress Code

Neatness of appearance, personal cleanliness, and wearing appropriate clothing in your professional environment is essential when in contact with patients, visitors, and other employees.

Telephone Use

The Communications Department is responsible for providing an efficient, cost-effective telephone system.

Employees are responsible for using the telephone system appropriately, governed by the Rules of Professional Conduct and Confidentiality. Personal phone calls should be kept to a minimum; phone usage is primarily for business purposes.

At the request of the Graduate Medical Education Dept, all House Staff are issued a "TDX" authorization number, for business related toll calls. Hospital and Clinic policy limits the use of Authorization Codes and Calling Cards to business-related long-distance calls. Unless approved by a Department Director or Practice Manager all personal toll calls must be billed to a third party, to a personal calling card, placed collect, or placed at a pay station. GME audits the monthly Call Detail Reports provided by the Communications Department to assure that no unauthorized personal toll calls are placed. If abuse is discovered or suspected, GME will investigate the report and make an inquiry with the resident. Violators will be billed for unauthorized calls at the rate of an operator-assisted call. Abuse of the telephone system constitutes misappropriation of funds and may result in disciplinary action.

Inspections

Inspections of Hospital Property

To control shortages, theft and to locate missing items, inspections of work and personal areas may be conducted at any time. Similarly, the hospital may conduct unannounced random inspections for drugs and alcohol on hospital facilities and property such as, but not limited to, hospital vehicles, equipment, desks, file cabinets, or hospital-issued lockers. Individuals who work at the hospital are expected to cooperate in the conduct of such inspections. Inspections of hospital facilities and property may be conducted at any time and do not have to be based on reasonable suspicion.

Inspections of House Staff Property

In addition to routine inspections conducted in accordance with loss prevention policies and practices, inspections of house staff and their personal property such as, but not limited to, vehicles, clothing, packages, purses, brief cases, lunch boxes, or other containers brought into the hospital premises may be conducted when there is reasonable suspicion to believe that the individual may have or has violated the drug or alcohol prohibitions contained in this policy manual.

Notary Public

There is a Notary Public in the Graduate Medical Education Office. ***Please remember: You must sign documents to be notarized in the presence of the notary.*** There is no charge for this service.

Security

Security measures are provided within the institution, including foot and vehicle patrol of the facilities and general response to problems that arise. Security also provides a lost-and-found department, assistance with ambulance security, transportation of patients to and from aircraft into the hospital, unlocking doors, escorts to vehicles, and assistance with cars that will not start in the middle of the night.

Smoking

Mary Hitchcock Memorial Hospital and the Dartmouth-Hitchcock Clinic are committed to providing a healthy, productive and safe environment for their patients, employees and visitors. Medical evidence clearly shows that smoking is harmful to the health of smokers. Smoke from cigarettes, cigars and pipes is also an irritant to many non-smokers and can worsen allergic conditions. Research indicates that long-term exposure to second-hand smoke will seriously threaten the health of the non-smoker.

In keeping with Dartmouth-Hitchcock's mission and vision to advance health and achieve the healthiest population possible in our region, DHMC will be a Smoke-Free/Tobacco-Free Campus by July 4, 2008. Smoking will not be allowed outside public entrances of the Hospital and/or Clinic by patients, visitors, employees, or house staff, or on Medical Center property.

The success of this policy will depend upon the thoughtfulness, consideration and cooperation of smokers and non-smokers. All persons share in the responsibility for adhering to and enforcing the policy.

The management of Mary Hitchcock Memorial Hospital and the Dartmouth-Hitchcock Clinic realize that it will be difficult for some employees to refrain from smoking in the workplace. Dartmouth-Hitchcock offers many resources in the area of tobacco cessation, many of which can be found online at http://www.dhmc.org/goto/tobaccofree

IX. DHMC PROFESSIONAL CONDUCT POLICIES AND PROCEDURES

Code of Professional Conduct

The Dartmouth-Hitchcock Medical Center (DHMC) and its component institutions are committed to excellence in patient care, education and training, research; public service, and organizational/business conduct. To further the goal of excellence, all professionals at DHMC are expected to adhere to the Code of Professional Conduct in their interactions with patients, colleagues, health professionals, students, trainees, and the public. *All* DHMC employees, including nonprofessionals and volunteers, adhere to the Core Code of Ethical Conduct.

Professionals at DHMC are essential to our mission. All professionals at DHMC have self-imposed obligations that exceed legal and regulatory requirements. Professionals have responsibilities to the public, their colleagues, and those whom they serve. Our professions bring distinguished traditions of honorable and trustworthy conduct which help create our distinctive professional reputation.

The Code of Professional Conduct is a series of principles and their subsidiary rules that govern professional interactions. The Code consists of two complementary sections: professional obligations and professional ideals. "Obligations" refer to *necessary* professional behaviors that are required by the ethical foundation of medical practice, teaching, learning, research, and business conduct. "Ideals" refer to *desirable* professional behaviors to which professionals at all levels should aspire.

The Code applies to all professionals at DHMC but certain portions of the Code are more directly applicable to some disciplines than to others. Some have direct application in clinical settings, while others are applicable to teaching, research, or business activities. The general portions of the Code which discuss confidentiality, conflicts of interest, interpersonal relations, and professional ideals apply to all DHMC professionals because they are based on common principles of professionalism.

Failure to meet the professional obligations described below represents a violation of the DHMC Code of Professional Conduct. Items marked with an asterisk indicate behaviors that may additionally violate federal or state laws. Alleged infractions of the professional obligations of the Code will be dealt with by the appropriate DHMC disciplinary committees and processes. Alleged failure to meet the professional ideals, although less serious, also may be grounds for disciplinary review.

A. Professional Obligations

1. Respect for Persons

- Treat those whom you serve, with whom you work, and the public with the same degree of respect you would wish them to show you.
- Treat patients and colleagues with kindness, gentleness, and dignity.
- Respect the privacy and modesty of patients.
- Do not use offensive language, verbally or in writing.
- Do not harass others physically, verbally, psychologically, or sexually. *
- Do not discriminate on the basis of sex, religion, race, disability, age, or sexual orientation. *

2. Patient Confidentiality

- Do not share the medical or personal details of a patient with anyone except those health care professionals integral to the well being of the patient or within the context of an educational endeavor. *
- Do not seek confidential data on patients without a professional "need to know." *
- Do not discuss patients or their illnesses in public places where the conversation may be overheard.
- Do not publicly identify patients, in spoken words or in writing, without adequate justification.
- Do not invite or permit unauthorized persons into patient care areas of the institution.
- Do not share your confidential Clinic Information System or Veterans Affairs computer system passwords with unauthorized persons.

3. Confidential and Proprietary Information

- Do not share details of employee or staff grievances.
- Do not share the personal compensation data of others beyond those with a need to know.
- Do not discuss personal information about colleagues or coworkers.
- Do not discuss business negotiations outside of the context of the negotiation itself.
- Do not misuse electronic mail for patient or business purposes.

4. Honesty, Integrity

- Be truthful in verbal and in written communications.
- Acknowledge your errors of omission and commission to colleagues and patients.
- Protect the integrity of clinical decision making, regardless of how the medical center shares financial risk with or compensates its leaders, managers, and clinical staff.
- Do not knowingly mislead others.
- Do not cheat, plagiarize, or otherwise act dishonestly.
- Do not abuse special privileges, e.g., by making unauthorized long-distance telephone calls.
- Be truthful in all negotiations and business transactions.

5. Responsibility for Patient Care

- Obtain the patient's informed consent for diagnostic tests or therapies.
- Assume 24-hour responsibility for the patients under your care; when off duty, or on vacation, assure that your patients are adequately cared for by another practitioner.
- Follow up on ordered laboratory tests and complete patient record documentation conscientiously.
- Coordinate with your team the timing of information sharing with patients and their families to present a coherent and consistent treatment plan.
- Charge patients or their insurers only for clinical services provided or supervised. *

- Do not abuse alcohol or drugs that could diminish the quality of patient care or academic performance.
- Do not have romantic or sexual relationships with patients; if such a relationship seems to be developing, seek guidance and terminate the professional relationship.*
- Do not abandon a patient. If you are unable/unwilling to continue care, you have an obligation to assist in making a referral to another competent practitioner willing to care for the patient.
- Cooperate with other members of the health care team in clinical activities.

6. Awareness of Limitations, Professional Growth

- Be aware of your personal limitations and deficiencies in knowledge and abilities and know when and whom to ask for supervision, assistance, or consultation.
- Know when and for whom to provide appropriate supervision.
- Assure that students and other trainees have all patient workups and orders countersigned by the appropriate supervisor.
- Avoid patient involvement when you are ill, distraught, or overcome with personal problems.
- Do not engage in unsupervised involvement in areas or situations where you are not adequately trained.
- Act in accordance with your authorized role and level of responsibility.
- Keep abreast of professional, technological, and regulatory developments.

7. Deportment

- Clearly identify yourself and your professional level to patients and staff; wear your name tag when in patient areas.
- Dress in a neat, clean, professionally appropriate manner.
- Maintain a professional composure despite the stresses of fatigue, professional pressures, or personal problems.
- Do not introduce medical students as "doctor" or allow yourself as a medical student to be introduced as "doctor."
- Do not write offensive or judgmental comments in patients' charts.
- Do not criticize the medical decisions of colleagues in the presence of patients.
- Avoid the use of first names without permission in addressing adult patients.
- Conduct yourself in a professional manner as a representative of the organization.

8. Avoiding Conflicts of Interest

- Resolve all clinical conflicts of interest in favor of the patient.
- Avoid conflicts of interest whenever possible. Disclose all real or perceived conflicts of interest.
- Maintain your objectivity in all decision making and avoid creating any perceptions of impaired objectivity.

- Do not accept non-educational gifts of value from any existing or potential vendor, supplier, or consultant.
- Do not participate in incentive programs, especially when this involves prescribing drugs made by the company.
- Do not refer patients to laboratories or other agencies in which you have a direct financial stake. *
- Do not accept a "kickback" for any patient referral. *
- Do not recommend or participate in the negotiation of any contract from which you or your family would receive any direct or indirect financial benefit.
- Do not participate in personnel recruitment or performance management which would benefit you or members of your family.

9. Responsibility for Self and Peer Behavior

- Take the initiative to identify and help rehabilitate impaired students, physicians, nurses, and other employees with the assistance of the DMS Student Needs and Assistance Program, the DHMC Physicians Health Committee, the MHMH and HC Employee Assistance Program, or the employee's supervisor.
- Report serious breaches of the Code of Professional Conduct to the appropriate person.
- Indicate disapproval or seek appropriate intervention if you observe less serious breaches.
- Seek input and feedback from patients and colleagues on your own professional behavior.

10. Respect for Personal Ethics

- You are not required to perform procedures (e.g., elective abortions, termination of medical treatment) that you, personally, believe are unethical, illegal, or may be detrimental to patients.
- You have an obligation, however, to inform patients and their families of available treatment options that are consistent with acceptable standards of medical and nursing care.

11. Respect for Property and Laws

- Adhere to the regulations and policies of Dartmouth College , DHMC, and its component institutions, e.g., policies governing fire safety, hazardous waste disposal, and universal precautions.
- Adhere to local, state, and federal laws and regulations.
- Do not misappropriate, destroy, damage, or misuse property of DHMC or its component institutions. *
- Conduct business in accordance with all pertinent laws and regulations.

12. Integrity in Research

- Report research results honestly in scientific and scholarly presentations and publications.
- When publishing and presenting reports, give proper credit and responsibility to colleagues and others who participated in the research.

- Report research findings to the public and press honestly and without exaggeration.
- Avoid potential conflicts of interest in research; disclose funding sources, company ownership, and other potential conflicts of interest in written and spoken research presentations.
- Adhere to the institutional regulations that govern research using human subjects and animals.
- Cooperate with other members of the research team in research activities.

B. Professional Ideals

1. Clinical Virtues

- Strive to cultivate and practice clinical virtues, such as caring, empathy, and compassion.

2. Conscientiousness

- Fulfill your professional responsibilities conscientiously.
- Notify the responsible supervisor if something interferes with your ability to perform clinical tasks effectively.
- Learn from experience and knowledge gained from errors in order to avoid repeating them.
- Dedicate yourself to lifelong learning and self-improvement by implementing a personal program of continuing education and continuous quality improvement.
- Students and trainees should complete all assignments accurately, thoroughly, legibly, and in a timely manner.
- Students and trainees should attend scheduled classes, laboratories, seminars, and conferences except for justified absences.

3. Collegiality

- Teach others at all levels of education and training.
- Be generous with your time to answer questions from trainees, patients, and patients' family members.
- Shoulder a fair share of the institutional administrative burden.
- Adopt a spirit of volunteerism and altruism in teaching and patient care tasks.
- Use communal resources (equipment, supplies, and funds) responsibly and equitably.

4. Personal Health

- Develop a life style of dietary habits, recreation, disease prevention, exercise, and outside interests to optimize physical and emotional health and enhance professional performance.

5. Objectivity

- Avoid providing professional care to members of your family or to persons with whom you have a romantic relationship.

6. Responsibility to Society

- Avoid unnecessary patient or societal health care monetary expenditures.
- Provide services to all patients regardless of their ability to pay.

7. Advancement of Professionalism

- Actively discuss and develop improved professionalism in society, professional organizations, and regulatory bodies.

* Behaviors that also may violate federal or state laws.

X. EMERGENCY COURSE REQUIREMENTS AT DHMC

Basic Life Support (BLS) Healthcare Provider (CPR)

Course content:
One and two person adult resuscitation
One person child & infant resuscitation
Obstructed airway management in the adult, child, & infant
Mouth/to/mask & bag-valve-mask ventilation
Automated external defibrillation using Philips AED

Requirement:
Required for every physician
*BLS Healthcare Provider may be achieved at either Provider or Instructor level.

Length of recognition: Two years

Course schedule: Provider training for house staff during orientation to DHMC if not completed within past six months; recertification available every May thereafter.
Provider training held second Wednesday of every month from 9 to 3 p.m.

Cost of course: No charge for Provider Course ($10 for text)

Advanced Cardiac Life Support (ACLS)

Course content:
Advanced airway management
Pharmacological intervention
Defibrillation/external pacing
Acute coronary syndrome
Acute ischemic stroke
Cardiac rhythm disturbances
Post resuscitation care

Requirement:
Required for Internal Medicine and Anesthesia house staff, GL 2 & 3.
Desirable for Pediatric house staff, GL 2 & 3.
*ACLS may be achieved at either Provider or Instructor level.

Length of recognition: Two years

Course schedule: Provider & Provider Recertification Courses are held during year; see Life Support Program poster and web page.

Cost of course: No charge to CPR Team members.
Others: $100 for Provider Course (texts included) & $50 for Provider Recertification Course ($38 additional for texts)

Advanced Trauma Life Support (ATLS)

Course content:
- Initial assessment
- Airway management
- Shock
- Thoracic trauma
- Abdominal trauma
- Head trauma
- Spine trauma
- Musculoskeletal trauma
- Burn and cold injuries
- Extremes of age (Peds & Geriatrics)
- Trauma in women

Requirements: Required for General Surgery house staff prior to GL-3 year; Anesthesia house staff prior to GL-4 year.
*ATLS may be achieved at the provider level

Length of recognition: Four years

Course schedule: Provider courses are generally scheduled twice per year

Cost of course: No charge for General Surgery and Anesthesia house staff,
Others: $425 for provider course

Pediatric Advanced Life Support (PALS)

Course content:
- Airway management
- Pharmacological intervention
- Cardiac rhythm disturbances
- Defibrillation
- Arrest prevention
- Fluid resuscitation
- Neonatal resuscitation

Requirement: Required for all Pediatric house staff, GL 1, 2 & 3
*PALS may be achieved at Provider or Instructor level

Length of recognition: Two years

Course schedule: Provider & Provider Recertification Courses are held during year; see Life Support Program poster and web page

Cost of course: No charge to CPR Team members
Others: $225 for Provider Course (texts included) & $75 for Provider Recertification Course ($40 additional for texts)

Neonatal Resuscitation Program (NRP)

Course content: Delivery room management
Initial steps of resuscitation
Use of bag/valve device
Chest compressions
Endotracheal intubation
Pharmacological intervention

Requirement: Required for all Pediatric house staff, GL 1, 2 & 3
*NRP may be achieved at Provider or Instructor level

Length of recognition: Two years

Course schedule: Several courses are held during year; watch for poster

Cost of course: No charge

Automated External Defibrillation Competency

Course content: Automated defibrillation operation using Philips Heartstart FR2 device

Requirement: Required for all house staff.

Length of recognition: Two years

Course schedule: For all house officers during orientation to DHMC;

Cost of course: No charge

Manual Defibrillation Competency

Course content: Manual defibrillator/external pacemaker operation using Zoll M Series device

Requirement: Required for all Internal Medicine, Pediatric, and Anesthesia house officers;
Psychiatric house officers GL 1 only; Family Practice GL 2 & 3 levels;
Obstetrics/Gynecology GL level 1; Critical Care, Pediatric and Cardiology fellows.

Length of recognition: Two years

Course schedule: For designated house officers during orientation to DHMC;
during ACLS course for Internal Medicine house officers at end of GL 1 year

Cost of course: No charge

For more information about life support courses and sign-up, call Life Support Program, ext. 5-7089.
(JB Emergency Course Requirements for HOs.doc 08/31/05)

Basic Life Support (BLS) Training Policy

The following excerpt from the 2004 "Cardiopulmonary Resuscitation (CPR) Policies", developed by the CPR Committee and approved by the Board of Governors, relates to the institutional policy for BLS.

It is well documented that training and competency in Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and Neonatal Resuscitaion Program (NRP) substantially improve performance of life support skills involved in a resuscitation. Additionally, CPR and early defibrillation have been shown to improve patient survival. In order to insure that BLS is administered as quickly as possible to a victim of cardiopulmonary arrest, it is required that all health care providers who deliver direct patient care or support personnel who come in direct contact with patients demonstrate competency in BLS every two years as evidenced by completing the American Heart Association Health Care Provider Course or the Heartsaver with Automated External Defibrillator Course - or its equivalent as judged by the Life Support Program Coordinator. These providers include, but are not limited to:

All members of MHMH Professional Staff as defined by the Office of Clinical Affairs:

- Doctor of Osteopathy (DO)
- Foreign equivalent of MD (MBBS)
- Doctor of Medicine (MD)

IMPLEMENTATION POLICY

Each department will determine the categories of staff who are direct care providers or support personnel who come in direct contact with patients and must be trained in BLS. All designated persons will be trained in BLS within eight weeks of employment and/or appointment and will continue to demonstrate competence every two years. If a new employee is already current in BLS, then only certification in the automated external defibrillator (AED) used at DHMC must occur.

A penalty may be imposed if BLS status is not current for an individual. A grace period of one month is extended for those who must recertify in BLS.

a. Attending staff are not granted admitting privileges unless BLS is current.

b. If a nurse, technologist, or technician is not retrained by the end of the following month after her/his BLS expiration date, she/he will be suspended without pay until competency is demonstrated. A contract for BLS retraining will then be established with the appropriate leadership person.

c. If a house staff member is not retrained by the end of the following month after his/her BLS expiration date, he/she may lose medical staff privileges.

If a person is unable to perform the BLS skills due to a physical disability or medical condition, the BLS written test must be completed and a written physician verification must be given to one's supervisor and reviewed annually.

5/05

XI. Electronic Communications

Guidelines for the Use of E-Mail in Clinical Communications

Introduction

E-mail is a good method for quick and efficient communications among providers and, in a more limited way, among providers and patients. E-mail is easy and convenient, replaces telephone calls and reduces telephone tag. It can be posted and read at any time, and is an integral part of our business because, by increasing efficiency, it contributes to improved patient care.

Intent of This Document

The use of e-mail in clinical communication has many advantages, but there are also some potential risks that e-mail users should bear in mind. The intent of this document is neither to require nor prohibit the use of e-mail in clinical communications, but rather to set forth guidelines and warnings for its appropriate use. The advantages of using e-mail in patient care greatly outweigh the risks.

Patient Confidentiality

The same considerations of patient confidentiality apply to the use of e-mail in clinical communications as to any other clinical communication. (See below for some specific suggestions).

Warnings

E-mail communications (including "trash," which can be retrieved from a hard disc) are discoverable by subpoena and may be used in legal proceedings.

Security is not assured. At this time DHMC e-mail is not encrypted (i.e., coded to prevent unauthorized viewing). Once sent, e-mail can be forwarded, changed, stored, or printed without the sender's knowledge. E-mail communication is asynchronous, that is, the receiver picks up e-mail at a time of her/his choosing, not the sender's. There may be no immediate feedback. E-mail systems may be down for unexpected and unpredictable periods of time. The emotional context and subtle nuances of communication are diminished, if not lost, through the use of e-mail technology. Some e-mail properly belongs in the medical record (see below), but practices and policies will vary from provider to provider or institution to institution. Be aware that the sender and receiver may have different rules about what is included in the medical record and that the same e-mail message may be incorporated in the medical record at one institution, and not at another. E-mail may be inadvertently sent to unauthorized recipients at the touch of button. Exercise every caution in making sure the e-mail transmittal is addressed to the right party and only to that party.

Guidelines

Use professional language, titles, content, and tone. If the text is for chart documentation, refer to only one patient in a message, and include the medical record number and name of the patient (but not in the header). Patient consent to use e-mail for communications is not necessary but in order to avoid misunderstandings a clinician may wish to document the circumstances under which a clinician and patient have agreed to communicate by e-mail. General e-mail protocols and courtesies should be observed (See the DHMC home page for general guidelines on e-mail use).

Use of E-Mail to Create and/or Distribute Medical Record Documentation. There is a function in the Clinical Information System (CIS) that was developed to facilitate e-mail transfer of clinical information between providers. This function is easy to use, has built-in privacy warnings to both sender and receiver, and there is an audit trail to document appropriate usage. This function should be used whenever possible. It is better to use

the "Notes" function in CIS for documentation for the medical record than the e-mail system. "Notes" have the advantage that they are linked both to provider and to the patient record, thereby eliminating the need for the clinician to print, authenticate, and deliver a copy of the e-mail communication to Medical Records.

E-mail may be used by secretaries and transcriptionists to transmit already transcribed letters and reports from one provider to another provider, or, where appropriate, from provider to patient.
(Source: *DHMC Information Systems Policies and Guidelines, 11-00* – www.hitchcock.org/intranet/IS/library/docs/email.htm)

XII. Environmental Principles

Statement of Environmental Principles

In an effort to promote healthier communities both locally and globally, Dartmouth-Hitchcock Medical Center (DHMC) is committed to improving environmental management throughout the organization. DHMC will manage its operations in a manner demonstrably protective of environmental and human health.

DHMC will constantly seek new and innovative ways to meet its environmental goals through conservation, reduction, reuse and recycling programs, and through partnering with others in the community to safeguard the environment.

DHMC will apply these principles to achieve optimal environmental standards consistent with institutional goals and financial considerations.

In an effort to respect and protect the earth's resources, and to minimize environmental damage, DHMC will:

- Manage, minimize and eliminate, whenever possible, the use of hazardous materials.
- Use renewable natural resources and conserve non-renewable natural resources through cost efficient use and careful planning.
- Use pollution prevention initiatives to reduce negative environmental impacts.
- Minimize the generation of waste through source reduction, re-use and recycling programs.
- Conserve energy and improve the energy efficiency of our operations and make every effort to use and promote environmentally safe, cost-effective and sustainable energy sources.
- Ensure the health and safety of our employees and house staff by promoting safe work practices, reducing exposure, using safe technologies, and implementing effective emergency preparedness programs.
- Provide employees and house staff with safety and environmental information through training and education programs in order for them to make work/practice decisions in support of these principles.

HITS Manual Mission Statement

DHMC maintains a *Hazardous Infectious Training Safety Manual* that outlines data sheets and procedures relative to a broad range of materials. *HITS* is available in a hard-copy form in all departments. It is also available online through the DHMC Intranet. Each area of the facility has a designated *HITS* coordinator.

The purpose of the *HITS Manual* is:

- To ensure policies, procedures and material safety data sheets are accessible and available at all times.
- To standardize the information available to employees.
- To facilitate the recognition of the *HITS Manual* in every area by standardization of the appearance of the binder.
- To facilitate the dissemination of information contained in the *HITS Manual* by designating a "*HITS* Coordinator" in each area.

INDEX